Section 5. Medicare

Medicare, authorized under title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital insurance (part A) program and the supplementary medical insurance (part B) program.

ELIGIBILITY

Most Americans age 65 or older are automatically entitled to protection under part A. Persons age 65 or older who are not ``fully insured'' (i.e., not eligible for monthly Social Security or railroad retirement cash benefits) may obtain coverage, providing they pay the full actuarial cost of such coverage. For those who are not automatically entitled to part A benefits, the full monthly premium, as of January 1, 1994, is $245. Also eligible, after a 2-year waiting period, are people under age 65 who are receiving monthly Social Security benefits on the basis of disability and disabled railroad retirement system annuitants. (Dependents of the disabled are not eligible.) Most people who need a kidney transplant or renal dialysis because of chronic kidney disease are, under certain circumstances, entitled to benefits under part A regardless of age.

Part B of Medicare is voluntary. All persons age 65 or older (whether ``insured'' or not) may elect to enroll in the

supplementary medical insurance program by paying the monthly premium. Persons eligible for part A by virtue of disability or chronic kidney disease may also elect to enroll in part B. The premium, as of January 1, 1994, is $41.10 per month.

NUMBER OF BENEFICIARIES

In fiscal year 1994, approximately 32.1 million aged and 4.1 million disabled will have protection under part A. Of those, it is estimated that 7.0 million aged and 0.9 million disabled will actually receive reimbursed services. In fiscal year 1994, 31.4 million aged and 3.7 million disabled will be enrolled in part B. About 26.7 million of the aged and 3.0 million of the disabled will receive part B reimbursed services.

TABLE 5-1.--NUMBER OF AGED AND DISABLED ELIGIBLE ENROLLEES AND BENEFICIARIES, AND AVERAGE AND TOTAL MEDICARE BENEFIT PAYMENTS

[Persons in thousands]

Fiscal year	Projected average annual growth (percent)
1996\1\	

1975 (actual)	1980 (actual)	1985 (actual)	1990 (actual)	1991 (actual)	1992 (estimate)	1993\1\ (estimate)	1994\1\ (estimate)	1995\1\ (estimate)	1975-85	1985-90	1990-96
Part A:											
Persons enrolled (monthly) average):											
Aged	21,795	24,571	27,123	29,801	30,456	30,808	31,630	32,054	32,432	32,763	2.2	1.9	1.6
Disabled	2,047	2,968	2,944	3,270	3,380	3,561	3,833	4,094	4,389	4,683	3.7	2.1	6.2
Total	23,842	27,539	30,067	33,071	33,836	34,369	35,463	36,148	36,821	37,446	2.3	1.9	2.1
Beneficiaries receiving reimbursed services:											
Aged	4,906	5,943	6,168	6,070	6,110	6,710	6,820	6,960	7,100	7,230	2.3	-0.3	3.0
Disabled	456	721	672	680	700	735	805	865	935	1,000	4.0	0.2	6.64.6
Total	5,362	6,664	6,840	6,750	6,810	7,445	7,625	7,825	8,035	8,230	2.5	-0.3	3.4
Average annual benefit per person enrolled:\2\\3\											
Aged	$326	$853	$1,563	$1,971	$2,007	$2,324					

$2,539 $2,800 $3,009 $3,260 17.0
4.7 8.7
Disabled.....
$345 $948 $1,806 $2,139 $2,177 $2,527
$2,665 $2,861 $3,024 $3,232 18.0
3.4 7.1
Total.....
$327 $863 $1,587 $1,987 $2,024 $2,345
$2,553 $2,807 $3,010 $3,257 17.1
4.6 8.6
Part B:
Persons enrolled (average):
Aged.....
21,504 24,422 27,049 29,426 29,910 30,471
30,982 31,354 31,697 32,000 2.3
1.7 1.4
Disabled.....
1,835 2,698 2,672 2,907 3,023 3,163
3,383 3,656 3,954 4,244 3.0
1.7 6.5
Total.....
23,339 27,120 29,721 32,333 32,933 33,634
34,365 35,010 35,651 36,244 2.4
1.7 1.9
Beneficiaries receiving reimbursed services:
Aged.....
11,311 16,034 20,199 23,820 24,115 25,603
25,994 26,682 27,355 27,968 6.0
3.4 2.7
Disabled.....
797 1,669 1,933 2,184 2,276 2,522
2,772 3,031 3,326 3,620 9.3
2.5 8.8
Total.....
12,108 17,703 22,132 26,004 26,391 28,125
28,766 29,713 30,681 31,588 6.2
3.3 3.3
Average annual benefit per person enrolled:\2\
Aged.....
$153 $347 $705 $1,250 $1,342 $1,403
$1,474 $1,593 $1,781 $1,957 16.5

12.1 7.8
Disabled.....
$259 $615 $1,021 $1,602 $1,758 $1,847
$1,994 $1,863 $2,005 $2,181 14.7
9.4 5.3
Total.....
$161 $374 $733 $1,282 $1,380 $1,445
$1,525 $1,621 $1,806 $1,983 16.3
11.8 7.5

\1\Represents current law. Does not include regulations or legislative proposals.
\2\Does not include administrative cost.
\3\Includes Part A catastrophic benefits beginning in fiscal year 1989. There are no catastrophic benefits after fiscal year 1990.

Source: Health Care Financing Administration, Division of Budget.

TABLE 5-2.--BENEFIT PAYMENTS BY SERVICE UNDER MEDICARE PART A AND PART B FISCAL YEARS 1975, 1980, 1993, 1995 AND 1996

[In millions of dollars]

						1975		
1990		1993		1995 (est.)\1\		1996		
(est.)\1\		Projected average annual						
	1980							
	growth (percent)							
Fiscal year:								

(percent) 1985

Amount	(percent)	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	1990-96\1\	1975-85	1985-90
Part A:												
For inpatient hospital services.....		70.5	$9,947	67.4	65.0	55.2	$59,208	52.5	$75,021	50.1	$87,833	49.6	$96,110	16.3	5.5	8.4
For skilled nursing facility services.....		1.9	273	1.2	0.8	2.7	2,843	3.5	5,027	3.8	6,598	3.7	7,093	7.3	38.9	16.5
For home health services.....		0.9	133	1.5	2.7	3.1	3,352	6.7	9,529	8.6	15,074	8.9	17,217	30.5	11.9	31.4
For hospice services.....		0.0	0	0.0	0.0	0.3	318	0.7	958	0.8	1,341	0.8	1,538	NA	NA	30.0
Total benefit payments.....		73.3	10,353	70.1	68.6	61.3	65,721	63.3	90,535	63.3	110,846	62.9	121,958	16.5	6.6	10.9

Part B:
  For physician services..... 21.7
3,067 23.0 24.1 27.0 $28,968 23.6
33,800 22.9 $40,150 22.6 $43,762 18.5
11.5 7.1
  For outpatient services..... 3.7
529 5.3 5.6 7.8 8,365 8.3
11,916 8.5 14,833 8.7 16,915 22.2
16.4 12.5
  For other medical and health services..... 1.2
169 1.6 1.6 3.9 4,165 4.7
6,682 5.4 9,393 5.8 11,205 20.6
30.4 17.9

    Total benefit payments..... 26.7
3,765 29.9 31.4 38.7 41,498 36.7
52,398 36.7 64,376 37.1 71,882 19.2
13.7 9.6

==========

    Total..... 100.0
14,118 100.0 100.0 100.0 107,219 100.0
142,934 100.0 175,222 100.0 193,840 17.3
9.1 10.4

\1\Represents projections of current law.

 Source: Health Care Financing Administration, Division of Budget.

 TABLE 5-3.--BENEFIT PAYMENTS BY SERVICE UNDER MEDICARE PART A AND PART B, FISCAL YEARS 1975 THROUGH 1995

[In millions of dollars]

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Part A										
For inpatient hospital services.....	9,947	11,742	14,265	16,687	19,068	22,860	27,841	32,788	36,108	39,193
For skilled nursing facility services....	273	308	351	355	371	392	398	453	538	548
For home health service.....	133	217	289	357	433	524	655	1,102	1,456	1,716
For hospice services..	0	0	0	0	0	0	0	0	4	4
Total benefit payments.....	10,353	12,267	14,905	17,399	19,872	23,776	28,894	34,343	38,102	41,461
Part B										
For physician services	2,874	3,437	4,286	4,954	5,947	7,282	8,860	10,649	12,889	14,582
For radiology and pathology services...	193	251	313	373	449	531	654	743	609	615
For outpatient service	529	727	965	1,194	1,457	1,803	2,213	2,867	3,345	3,530
For other medical and										

health services......	169	257	303	331	406	528	618	547	644	746
Total benefit payments.......	3,765	4,672	5,867	6,852	8,259	10,144	12,345	14,806	17,487	19,473
Total...........	14,118	16,939	20,772	24,251	28,131	33,920	41,239	49,149	55,589	60,934

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994\1\	1995\1\
Part A											
For inpatient hospital services................	45,218	46,283	47,264	48,969	52,442	59,208	60,491	69,145	75,021	81,627	87,833
For skilled nursing facility services..........	550	577	630	742	2,327	2,843	2,512	3,645	5,027	6,152	6,598
For home health service........................	1,908	1,939	1,815	2,010	2,251	3,352	4,995	6,985	9.529	12,533	15,074
For hospice services...........................	34	68	104	137	211	318	479	808	958	1,138	1,341

Total benefit payments.....	47,710	48,867	49,813	51,858	57,231	65,721	68,477	80,584	90,535	101,450	110,846

Part B

For physician services.....	16,223	18,553	21,926	24,243	26,176	28,968	31,127	32,304	33,800	35,868	40,150
For radiology and pathology services.....	565	(\2\)	(\2\)	(\2\)	(\2\)	(\2\)	(\2\)	(\2\)	(\2\)	(\2\)	(\2\)
For outpatient service.....	3,917	4,937	5,793	6,466	7,321	8,365	9,234	10,671	11,916	12,985	14,833
For other medical and health services.....	1,103	1,679	2,218	2,973	3,370	4,165	5,153	5,620	6,682	7,899	9,393
Total benefit payments.....	21,808	25,169	29,937	33,682	36,867	41,498	45,514	48,595	52,398	56,752	64,376
Total.....	69,518	74,036	79,750	85,540	94,098	107,219	113,991	129,179	142,934	158,202	175,222

\1\Represents estimates of current law. Does not include legislative proposals. Includes catastrophic benefits, in

fiscal years 1989 and 1990.
\2\Not available. Physician services for fiscal years 1986 through 1994 include radiology and pathology services.

Source: Health Care Financing Administration, Division of Budget.

TABLE 5-4.--HISTORICAL AND PROJECTED AMOUNTS OF PART A (HOSPITAL INSURANCE) AND PART B (SMI) DEDUCTIBLE, COINSURANCE AND PREMIUMS\1\

For benefit periods beginning in calendar year	Inpatient hospital\2\ deductible	Skilled nursing facility coinsurance	HI monthy premium\6\	SMI premium
	First 60 days	61st thru 90th day	reserve days (nonrenewable)	21st thru 100th day
	Amount	Amount	Effective date	Full Effective date
	per day \3\	per day\4\	per day\5\	Reduced deductible
1966	$40	$10	(\7\)	(\7\)
1967	40	.....	.....	NA
	$50	7/66	$3.00	

10 (\7\) $5.00 ....
NA 50 ..... 3.00
1968..... 40
10 $20 5.00 ....
NA 50 4/68 4.00
1969..... 44
11 22 5.50 ....
NA 50 ..... 4.00
1970..... 52
13 26 6.50 ....
NA 50 7/70 5.30

1971..... 60
15 30 7.50 ....
NA 50 7/71 5.60
1972..... 68
17 34 8.50 ....
NA 50 7/72 5.80
1973..... 72
18 36 9.00 7/73 $33
NA 60 \8\9/73 6.30
1974..... 84
21 42 10.50 7/74 36
NA 60 7/74 6.70
1975..... 92
23 46 11.50 7/75 40
NA 60 ..... 6.70

1976..... 104
26 52 13.00 7/76 45
NA 60 7/76 7.20
1977..... 124
31 62 15.50 7/77 54
NA 60 7/77 7.70
1978..... 144
36 72 18.00 7/78 63
NA 60 7/78 8.20
1979..... 160
40 80 20.00 7/79 69
NA 60 7/79 8.70
1980..... 180

45 90 22.50 7/80 78
NA 60 7/80 9.60

1981..... 204
51 102 25.50 7/81 89
NA 60 7/81 11.00
1982..... 260
65 130 32.50 7/82 113
NA 75 7/82 12.20
1983..... 304
76 152 38.00 113
NA 75 ..... 12.20
1984..... 356
89 178 44.50 1/84 155
NA 75 1/84 14.60
1985..... 400
100 200 50.00 1/85 174
NA 75 1/85 15.50
1986..... 492
123 246 61.50 1/86 214
NA 75 1/86 15.50
1987..... 520
130 260 65.00 1/87 226
NA 75 1/87 17.90
1988..... 540
135 270 67.50 1/88 234
NA 75 1/88 24.80
1989..... \9\560
NA NA \10\25.50 1/89 156
NA 75 1/89 31.90
1990..... 592
148 296 74.00 1/90 175
NA 75 1/90 28.60

1991..... 628
157 314 78.50 1/91 177
NA 100 1/91 29.90
1992..... 652
163 326 81.50 1/92 192
NA 100 1/92 31.80
1993..... 676

169 338 84.50 1/93 221
NA 100 1/93 36.60
1994..... 696
174 348 87.00 1/94 245
184 100 1/94 41.10
1995\11\..... 720
180 360 90.00 1/95 264
185 160 1/95 46.10
1996\11\..... 748
187 374 93.50 1/96 285
186 100 1/96 42.80
1997\11\..... 788
197 394 98.50 1/97 307
185 100 1/97 47.10
1998\11\..... 836
209 418 104.50 1/98 332
183 100 1/98 52.10
1999\11\..... 884
221 442 110.50 1/99 359
197 100 1/99 53.80

\1\For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible for the year in which the services were furnished. For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began.

\2\For care in psychiatric hospital--190 day lifetime limit.

\3\Always equal to \1/4\ of inpatient hospital deductible through 1988, and for 1990 and later, eliminated for 1989.

\4\Always equal to \1/2\ of inpatient hospital deductible through 1988, and for 1990 and later, eliminated for 1989.

\5\Always equal to \1/8\ of inpatient hospital deductible through 1988 and for 1990 and later. For 1989 it was equal to 20 percent of estimated Medicare covered average cost per day.

\6\Not applicable prior to July 1973. Applies to aged individuals who are not fully insured, and to certain disabled individuals who have exhausted other entitlement. The reduced amount is available to aged individuals who are not fully insured but who have, or whose spouse has or had, at least 30 quarters of coverage under title II of the Social Security Act. The reduced amount is 75% of the full amount in 1994, 70% in 1995, 65% in 1996, 60% in 1997 and 55% in 1998 and thereafter.
\7\Not covered.
\8\For August 1973 the premium was $6.10.
\9\In 1989, the HI deductible was applied on an annual basis, not a benefit period basis (unlike the other years).
\10\In 1989, the SNF coinsurance was on days 1-8 of the 150 days allowed annually; for the other years it is on days 21-100 of 100 days allowed per benefit period.
\11\Administration projections under current law using fiscal year 1995 budget assumptions.

Note.--In addition to the deductible and coinsurance amounts shown in the table, the first 3 pints of blood are not reimbursed by Medicare. Currently there is no deductible or coinsurance on home health benefits. From January 1973 to June 30, 1982, there was a $60 annual deductible and prior to July 1, 1981, benefits were limited to 100 visits per benefit period under part A and 100 visits per calendar year under part B. Special limits apply to certain benefits: (1) Outpatient physican services for mental illness; 50 percent of approved charges, up to a maximum of $250 in benefits per year; July 1, 1966, through December 31, 1987; $450 in benefits per year, January 1, 1988, through December 31, 1988; $1,100 in benefits per year, January 1, 1989, through December 31, 1989; beginning January 1, 1990, the limit was removed; (2) physical and occupational therapy services furnished by physical therapists in independent practice: maximum annual approved charges July 1, 1973, through December 31,

1981, $80 per year; January 1, 1982, through December 31, 1982, $400 per year; and January 1, 1983, through December 31, 1989, $500 per year; January 1, 1990, and thereafter $750 per year.

Source: Health Care Financing Administration, Office of the Actuary, Office of Medicare and Medicaid Cost Estimates.

COVERAGE

Most individuals establish entitlement to part A on the basis of work in employment covered by either the Social Security or railroad retirement systems. Certain employment is excluded from Social Security (including part A hospital insurance) taxation.

The Tax Equity and Fiscal Responsibility Act of 1982 extended the hospital insurance tax to Federal employment effective with respect to wages paid on or after January 1, 1983. Beginning January 1, 1983, Federal employment is included in determining eligibility for protection under Medicare part A. A transitional provision allows individuals who were in the employ of the Federal Government both before and during January 1, 1983, to have their prior Federal employment considered as employment for purposes of providing Medicare coverage. Newly hired employees of State and local governments hired after March 31, 1986, are liable for the HI tax.

BENEFITS

Part A of Medicare will pay for:

1. Inpatient hospital care.--All reasonable expenses for the first 60 days minus a deductible ($696 in calendar year

1994) in each benefit period. For days 61-90, a coinsurance amount ($174 in calendar year 1994) is deducted. When more than 90 days are required in a benefit period, a patient may elect to draw upon a 60 day lifetime reserve. A coinsurance amount ($348 in calendar year 1994) is also deducted for each reserve day.

2. Skilled nursing facility care.--Up to 100 days (following hospitalization) in a skilled nursing facility for persons in need of continued skilled nursing care and/or skilled rehabilitation services on a daily basis. After the first 20 days, there is a daily coinsurance ($87 in calendar year 1994).

3. Home health care.--Home health visits provided to persons who need skilled nursing care, physical therapy, or speech therapy on an intermittent basis.

4. Hospice care.--Hospice care services provided to terminally ill Medicare beneficiaries with a life expectancy of 6 months or less up to a 210-day lifetime limit. A subsequent period of hospice coverage is allowed beyond the 210-day limit if the beneficiary is recertified as terminally ill.

Part B of Medicare generally pays 80 percent of the approved amount (fee schedule, reasonable charges, or reasonable cost) for covered services in excess of an annual deductible ($100). Services covered include the following:

1. Doctor's services.--Including surgery, consultation, and home, office and institutional visits. Certain limitations apply for services rendered by dentists, podiatrists and chiropractors and for the treatment of mental illness.

2. Other medical and health services.--Laboratory and other

diagnostic tests, X-ray and other radiation therapy, outpatient services at a hospital, rural health clinic services, home dialysis supplies and equipment, artificial devices (other than dental), physical and speech therapy, and ambulance services.

3. Home health services.--Unlimited number of medically necessary home health visits for persons not covered under part A. The 20 percent coinsurance and $100 deductible do not apply for such benefits.

Table 5-4 illustrates the deductible, coinsurance and premium amounts for both part A and part B services from the inception of Medicare.

ADMINISTRATION

Responsibility for administration of the Medicare program has been delegated by the Secretary of Health and Human Services to the Administrator of the Health Care Financing Administration (HCFA). Much of the day-to-day operational work of the program is performed by ``intermediaries'' and ``carriers'' which have responsibility for reviewing claims for benefits and making payments.

In general, hospitals and other providers paid under part A of Medicare can nominate, subject to HCFA's approval, a national, State, or other public or private agency to serve as a fiscal intermediary between themselves and the Federal Government.

The Secretary enters into contracts with insurance organizations to serve as carriers. The carrier must perform its obligations under the contract efficiently and

effectively
and must meet such requirements as to financial responsibility,
legal authority, and other matters as the Secretary finds pertinent. The carrier must ensure that payments made to providers under part B on a reasonable cost or reasonable charge basis (as may be applicable) are reasonable.

Medicare administrative costs in fiscal year 1993 amount to
approximately 1.9 percent of total program outlays.

Hospitals

The Social Security Amendments of 1983 (Public Law 98-21)
altered the way in which Medicare pays hospitals. From the inception of the program, Medicare had paid hospitals on a ``reasonable cost'' basis. Effective October 1, 1983, Medicare
began paying under a prospective payment system. Medicare payments for inpatient operating costs of hospitals are determined in advance and made on a per discharge basis. A fixed amount per case is paid based upon the type of case or
``diagnosis-related group'' (DRG) into which the case is classified.

The payment system is not applied to direct medical education costs and certain other costs. Certain hospitals are
excluded from the system: psychiatric, long-term care, children's cancer and rehabilitation hospitals. Excluded hospitals continue to be paid based on reasonable costs subject
to certain rate of increase limitations.

Additional payments are made for extraordinarily costly cases, for the indirect costs of medical education, and for hospitals serving a disproportionate share of low income patients. An adjustment is made for the wage level in the area
in which the hospital is located. In addition, there are certain other exceptions and adjustments including those

for
sole community providers, national and regional referral centers, and cancer treatment centers.

The prospective payment system was phased in over 4 years from payments based on an individual hospital's historical costs to payments based on the new payment rates. In addition, the system was phased in from payments representing nine regional payment levels to one national payment level for each DRG. There are separate payment levels for large urban, other urban, and rural areas. OBRA 1990 (P.L. 101-508) included a phaseout of the other urban/rural payment differential designed to eliminate the different payment levels for other urban and rural hospitals by fiscal year 1995. Once the phaseout is complete, there will be two payment levels for large urban and other hospitals.

Hospitals and other institutional providers receiving payment under Medicare part A submit bills on behalf of the beneficiary and agree to accept the program's payment as payment in full. In general, providers are permitted to charge beneficiaries only the deductible and coinsurance amounts authorized by law.

Physicians

Medicare part B provides insurance coverage for physician services and for certain other medical services. To be entitled to benefits under Medicare part B, individuals must enroll in part B and pay a monthly premium.

Payments are made for services covered under part B after

an annual deductible requirement of $100 has been satisfied. Payment is set at 80 percent of the Medicare fee schedule or other payment amount. Beneficiaries are responsible for the remaining 20 percent as coinsurance. A few services are exempt from deductible and coinsurance requirements.

Beginning January 1, 1992, a new physician payment system is being phased in over 5 years. It is based on a fee schedule that assigns relative values to services. Relative values reflect three things: physician work (time, skill and intensity involved in the service), practice expenses, and malpractice costs. These relative values are adjusted for geographic variations in the costs of practicing medicine. These adjusted relative values are then converted into a dollar payment amount by a conversion factor.

Medicare payment is made either on an ``assigned'' or ``unassigned'' basis. By accepting assignment, physicians agree to accept the Medicare approved amount as payment in full. Thus, if assignment is accepted, beneficiaries are not liable for any out-of-pocket costs other than standard deductible and coinsurance payments. In contrast, if assignment is not accepted, beneficiaries may be liable for charges in excess of the Medicare approved charge, subject to certain limits. This is known as balance billing.

Medicare's participating physician program was established in 1984 to provide beneficiaries with the opportunity to select

physicians who have agreed to accept assignment on all services
provided during a 12-month period. Nonparticipating physicians
continue to be able to accept or refuse assignment on a claim-
by-claim basis. A number of incentives are provided to encourage physicians to sign participation agreements. These
include: higher payment levels, more rapid claims payment, and
widespread distribution of participating physician directories.

TABLE 5-5.--PARTICIPATING INSTITUTIONS AND ORGANIZATIONS (JUNE 1984, 1989, 1990, 1991, 1992 AND 1993)

	1984	1989	1990	1991	1992	1993
Hospitals	6,675	6,508	6,520	6,487	6,457	6,417
Short stay	6,038	5,582	5,549	5,480	5,427	5,343
Long stay	637	926	971	1,007	1,030	1,074
Skilled nursing facilities	5,952	8,198	8,937	9,674	10,589	11,308
Home health agencies	4,684	5,546	5,730	5,826	6,175	6,828
Independent laboratories	3,801	4,613	4,879	4,926	7,526	7,547
Clinical laboratory independent act (CLIAs)	159,172	....	....	....	....	....
Outpatient physical therapy providers	791	1,082	1,195	1,317	1,435	1,618
Portable X-ray suppliers	269					

418	443	462	473	493
Rural health clinics.....				420
484	551	692	899	1,106
Comprehensive outpatient rehabilitation facilities.....				48
170	186	193	207	222
Ambulatory surgical centers.....				155
1,096	1,197	1,335	1,476	1,626
Hospices.....				108
703	825	1,057	1,199	1,395
Facilities providing services to renal disease beneficiaries.....				1,335
1,888	1,992	2,130	2,269	2,410
Hospitals certified as both renal transplant and renal dialysis centers.....				147
164	166	168	166	164
Hospitals certified as renal transplant centers.....				16
50	52	58	65	65
Hospital dialysis facilities.....				117
163	174	198	212	217
Non-hospital renal dialysis facilities.....				645
1,121	1,217	1,320	1,430	1,558
Dialysis centers only.....				359
332	1,882	331	337	347
Inpatient care.....				51
58	52	55	59	59
Hospital and skilled nursing facility beds:				
Hospitals.....			1,144,142	
1,103,359	1,104,574	1,101,823	1,096,647	1,089,196
Short stay.....			1,023,465	
973,013	970,480	966,577	960,616	951,433
Long stay.....			530,403	
130,346	134,094	135,246	136,031	137,763
Skilled nursing facilities.....			530,403	
492,999	508,585	567,199	597,234	616,633

Source: Health Care Financing Administration, BDMS, Decision Support Division.

Beginning in 1993, nonparticipating physicians are not allowed to charge more than 115 percent of Medicare's allowed amount for any service. Medicare's allowed amount for nonparticipating physicians is set at 95 percent of that for participating physicians. Thus, nonparticipating physicians are only able to bill 9.25 percent (115 percent times 95 percent) over the approved amount recognized for participating physicians.

The limits and participation differentials that now apply to physicians would be extended to other providers and practitioners when billing for a service covered under the physician fee schedule.

To provide incentives for physicians to get involved in efforts to stem expenditure increases, the law requires the calculation of annual Medicare volume performance standards (MVPSs), which are standards for the rate of expenditure growth. The relationship of actual expenditures to the MVPS is one factor used in determining the annual update in the conversion factor in a subsequent year.

A program to measure outcomes and effectiveness of the new system has been established. (Additional information concerning physician payment is included in appendix E.)

Table 5-5 above shows the number of participating institutions and organizations.

END STAGE RENAL DISEASE PROGRAM

The Medicare program covers individuals who suffer from end stage renal disease, if they are (1) fully insured for old

age
and survivor insurance benefits, or (2) are entitled to monthly
social security benefits, or (3) are spouses or dependents of
individuals described in (1) or (2). Such persons must be medically determined to be suffering from end stage renal disease and must file an application for benefits. Approximately 7 percent of the population suffering from end
stage renal disease (ESRD) do not meet any of these requirements and thus is not covered for Medicare renal benefits.

Benefits for qualified end stage renal disease beneficiaries include all part A (hospital insurance) and part
B (supplementary medical insurance) medical items and services.
ESRD beneficiaries are automatically enrolled in the part B portion of Medicare and must pay the monthly premium for such
protection.

Table 5-6 shows estimates of expenditures, number of beneficiaries, and the average expenditure per person from 1974
through 1999. Total projected program expenditures for Medicare
end stage renal disease program for fiscal year 1993 are estimated at $6.7 billion. In fiscal year 1993, there were an
estimated 184,257 beneficiaries, including successful transplant patients, and also including persons entitled to Medicare on the basis of disability who also have ESRD.

When the ESRD program was created, it was assumed that program enrollment would level out at about 90,000 enrollees by
1995. That mark was passed several years ago, and no indication
exists that enrollment will stabilize soon.

TABLE 5-6.--ESRD MEDICARE BENEFICIARIES AND PROGRAM

EXPENDITURES

[Expenditures in millions]

Fiscal year	Expenditures (HI & SMI)	HI beneficiaries	Per person
1974	$229	15,993	$14,319
1975	361	22,674	15,921
1976	512	28,941	17,691
1977	641	35,889	17,861
1978	800	43,482	18,398
1979	1,010	52,636	19,188
1980	1,250	55,509	22,519
1981	1,472	61,930	23,769
1982	1,651	69,552	29,738
1983	1,994	78,642	25,355
1984	2,336	87,929	26,567
1985	2,824	97,200	29,053
1986	3,159	106,633	29,625
1987	3,475	116,937	29,717
1988	3,909	127,487	30,662

1989.....	4,601	139,132	33,069
1990.....	5,093	152,541	33,388
1991.....	5,654	164,354	34,401
1992.....	6,124	174,454	35,104
1993.....	6,662	184,257	36,156
1994.....	7,266	194,201	37,415
1995.....	7,960	204,310	38,960
1996.....	8,754	214,564	40,799
1997.....	9,617	224,926	42,756
1998.....	10,580	235,351	44,954
1999.....	11,657	245,806	47,424

Note: Estimates for 1979-99 are subject to revision by the Office of the Actuary, Office of Medicare and Medicaid Cost Estimates; projections for 1994-99 are under the fiscal year 1995 budget assumptions.

Source: Office of the Actuary, Health Care Financing Administration, Department of Health and Human Services, for fiscal years 1979-99.

Table 5-7 shows that new enrollment grew an average annual rate of 9.7 percent from 1986 to 1991. Most of the growth

in
program participation is attributable to growth in the numbers
of elderly people receiving services and growth in the numbers
of more seriously ill people entering treatment. Table 5-7
shows the greatest rate of growth in program participation is
in people over age 75, at 15.7 percent, followed by the second
highest rate of growth in people ages 65 to 74 years old. This
age group exhibited a growth rate of 12.2 percent. The largest
rate of growth in primary causes of people entering ESRD
treatment was diabetes. People with diabetes frequently have
multiple health problems, making treatment for renal failure
more difficult.

TABLE 5-7.--MEDICARE END STAGE RENAL DISEASE PROGRAM NEW ENROLLMENTS BY AGE AND PRIMARY DIAGNOSIS: 1986-91

Age and primary diagnosis	1986	1987	1988	1989	1990	1991	Average annual percent change	Percent change 1990-91
Number of new enrollees:								
Total	32,061	35,081	38,151	42,885	46,658	50,831	9.7	8.9
Age:								
Under 15 years	420	430	403	405	461	454	1.6	-1.5

15-24 years	1,188	1,247	1,268	1,315	1,271	1,242	0.9	-2.3
25-34 years	2,992	2,852	3,087	3,413	3,438	3,485	3.1	1.4
35-44 years	3,659	3,989	4,340	4,704	5,133	5,501	8.5	7.2
45-54 years	4,450	4,893	5,390	5,904	6,230	6,753	8.7	8.4
55-64 years	7,217	7,885	8,456	9,108	9,819	10,587	8.0	7.8
65-74 years	7,937	8,972	9,669	11,302	12,682	14,097	12.2	11.2
75 years and over	4,198	4,813	5,538	6,734	7,624	8,712	15.7	14.3
Diagnosis:								
Diabetes	9,434	10,488	11,717	14,214	15,939	18,249	14.1	14.5
Glomerulonephritis	4,717	4,958	5,228	5,643	5,779	5,810	4.3	0.5
Hypertension	8,049	9,221	10,325	12,161	13,278	14,633	12.7	10.2
Polycystic-kidney disease	1,225	1,248	1,250	1,275	1,402	1,474	3.8	5.1
Interstit Nephritis	1,355	1,240	1,233	1,378	1,371	1,497	2.0	9.2
Obstructive Nephropathy	846	839	872	954	916	985	3.1	7.5
Other	1,879	2,016	2,182	2,596	2,788	3,456	13.0	24.0
Unknown	2,349	2,804	2,657	2,443	2,408	2,693	2.8	11.8
Missing	2,207	2,267	2,687	2,221	2,777	2,034	-1.6	-26.8

Source: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Program Management and Medical Information System, April 1993 update.

The rates of growth in older and sicker patients

entering
treatment for end stage renal disease indicate a shift in physician practice patterns. In the past, most of these people
would not have entered dialysis treatment because their age and
severity of illness made successful treatment for renal failure
less likely. Although the reasons that physicians have begun
treating older and sicker patients are not precisely known, it
is clear that these practice patterns have, and will continue,
to result in steady growth in the numbers of patients enrolling
in Medicare's end stage renal program.

End stage renal disease is invariably fatal without treatment. Treatment for the disease takes two forms: transplantation and dialysis. Although the capability to perform transplants had existed since the 1950's, problems with
rejection of transplanted organs limited its application as a
treatment for renal failure. The 1983 introduction to the market of a powerful and effective immunosuppressive drug, cyclosporine, resulted in a dramatic increase in the numbers of
transplants being performed and the success rate of transplantation.

Table 5-8 indicates that the number of transplants in 1992
was more than double the number performed in 1980. Despite the
significant increases in the number and success of kidney transplants, transplantation will not be the treatment of choice for all ESRD patients. A chronic, severe shortage of kidneys available for transplantation now limits the number of
patients who can receive transplants. Even absent a shortage of

organs, some patients are not suitable candidates for transplants because of their age, severity of illness or other complicating conditions. And some ESRD patients do not want an organ transplant.

For all of these reasons, dialysis is likely to remain the primary treatment for end stage renal disease. Dialysis is an artificial method of performing the kidney's function of filtering blood to remove waste products. There are two types of dialysis: hemodialysis and peritoneal dialysis. In hemodialysis, still the most common form of dialysis, blood is removed from the body, filtered and cleansed through a dialyzer, sometimes called an artificial kidney machine, before being returned to the body. Peritoneal dialysis does not require use of a machine. Instead, filtering takes place inside the body by inserting dialysate fluid through a permanent surgical opening in the peritoneum (abdominal cavity). Toxins filter into the dialysate fluid and are then drained from the body through the surgical opening. To be effective, both types of dialysis generally need to be performed several times a week, usually three times.

TABLE 5-8.--TOTAL KIDNEY TRANSPLANTS PERFORMED IN MEDICARE CERTIFIED U.S. HOSPITALS

Calendar year	Total transplants	Living donor	Cadaveric donor

Number	Percent	Number	Percent
1979			
4,189	1,186	28	3,003	72
1980			
4,697	1,275	27	3,422	73
1981			
4,883	1,458	30	3,425	70
1982			
5,358	1,677	31	3,681	69
1983			
6,112	1,784	29	4,328	71
1984			
6,968	1,704	24	5,364	76
1985			
7,695	1,876	24	5,819	76
1986			
8,976	1,887	21	7,089	79
1987			
8,967	1,907	21	7,060	79
1988			
8,932	1,760	20	7,116	80
1989			
8,899	1,893	21	7,006	79
1990			
9,796	2,091	21	7,705	79
1991			
10,026	2,382	24	7,644	76
1992			
10,115	2,536	25	7,579	75

Source: HCFA, BDMS, OSDM, Division of Special Programs.

Since 1983, Medicare has reimbursed outpatient maintenance dialysis on the basis of a fixed rate which is adjusted to reflect the proportion of patients dialyzing at home. Separate rates are established for hospitals and for independent, or

free-standing, facilities. Both rates were originally derived from audited costs; both are divided into nonlabor and labor components. The labor component is adjusted by a wage index to reflect differences in wages. In addition, the hospital rate contains two additional adjustments which result in slightly higher rates. One adjustment consists of a 5 percent add-on to the overall rate to account for possible data collection errors, and the second adjustment consists of a $2.10 add-on per treatment to account for hospitals' additional overhead. The fixed rate is paid for each treatment.

When this rate structure was implemented in 1983, HCFA estimated that the average payment for independent facilities would be around $127 per treatment and the average payment to hospitals would be approximately $131. In 1986, HCFA proposed to lower the rates, based on 1983 audit data which showed declining costs. The rates HCFA proposed to implement would have resulted in an average rate of $115.40 for independent facilities and an average rate of $119.70 for hospital-based facilities. OBRA 1986 preempted the implementation of these rates by reducing each rate by $2.00. In OBRA 1989, Congress required that these rates be maintained until October 1, 1990. OBRA 1990 increased rates by $1, effective January 1, 1991. The current average payment rate for hospital renal facilities is $130 per treatment and the average payment rate for independent

renal facilities is $126 per treatment.

The effect of a dialysis rate that has been either fixed or declining since 1983 is less real spending per enrollee on dialysis services. Adjusting for inflation, dialysis reimbursement rates were nearly 65 percent lower in 1991 than they were in 1974. Considerable evidence documents increasing efficiency and lower costs associated with dialysis, but concerns that the rates have adversely affected quality and access to care remain. In OBRA 1987, Congress authorized the Institute of Medicine to conduct a comprehensive study of the ESRD program and the effects of the composite rate.

The Institute of Medicine (IOM) study required by OBRA 1987 was submitted to Congress in April 1991. As part of its mandate, the IOM examined several indicators of quality (mortality, morbidity, and dialysis staffing patterns). The IOM also examined the dialysis rate structure, commented on its implications for quality, and made a number of recommendations regarding ESRD dialysis rates. It found no conclusive evidence linking the composite rate to declining quality of care, as measured by mortality and morbidity. Nevertheless, the IOM suggested that there might be an indirect effect on quality of care due to the composite rate structure. It recommended modifications to the current rate structure, including updating the rates yearly and rebasing the rate structure after a comprehensive quality assurance program is established. It also recommended against further reductions in the composite rate and against rebasing the rate using current audit data because,

in its opinion, current costs may not include all services providers deem medically appropriate.

Recent changes

Dialysis payment rates.--OBRA 1989 mandated the continuance of the dialysis rates then in effect until October 1, 1990. In addition, it required the Secretary to follow standard regulatory procedures when proposing rate changes. OBRA 1990 increased the dialysis rates in effect on September 30, 1990, by $1 for services provided on or after January 1, 1991.

OBRA 1990 also directed the Prospective Payment Assessment Commission (ProPAC) to conduct a study to determine the costs, services and profits associated with various dialysis treatment modalities. The Commission was also required to make recommendations to Congress by June 1, 1992, on methods and levels of reimbursement for dialysis services. In its June 1992 report, ProPAC indicated that it has adopted an incremental approach to evaluating payment method and level and developing an update. The Commission will evaluate several options for unit of payment, including looking at larger bundles of services across longer time periods, recalculating base rates using more recent data, and using site of service and modality to determine payment.

In addition to this study, OBRA 1990 directed ProPAC to make a recommendation to Congress on an appropriate factor to be used in updating payments for services. ProPAC is to submit its recommendations to Congress by March 1 of each year for

the
succeeding fiscal year. In its March 1994 Report to Congress,
ProPAC did not recommend an increase in payments for dialysis
services.

Limitation of method II payments for home dialysis.--In January 1989, HCFA proposed to limit payments (called method II
payments) to suppliers who deal directly with Medicare beneficiaries rather than providing supplies through an approved Medicare dialysis facility. HCFA's proposed rule was
in response to information that one supplier received monthly
payments nearly twice as high as facilities received for dialyzing patients, either in-facility or at home. These rules
were not implemented.

Subsequently, the General Accounting Office conducted a study of method II payments. GAO concluded that the differential in payments between method I (payments to dialysis
facilities for home dialysis patients) and method II suppliers
was not justified. Shortly after GAO's report was released, Congress incorporated GAO's recommendations by enacting a payment limit on method II payments in OBRA 1989. The new limit
is 100 percent of the median dialysis rate paid to hospital-
based facilities. In the case of home patients on continuous
cycling peritoneal dialysis (CCPD), the limit is 130 percent of
the median hospital-based dialysis rate. The payment limit took
effect on February 1, 1990.

Staff-assisted home dialysis demonstration project.--In response to continuing congressional concerns about some home

dialysis patients' needs for staff assistance after the limitation on method II payments was imposed, OBRA 1990 established a 3-year demonstration project to determine whether Medicare coverage of staff assistants could be both cost effective and safe for patients. The demonstration was to begin within 9 months of OBRA 1990's enactment for a maximum of 800 participants. The law defines staff assistant services as including: technical assistance with operating the hemodialysis machine and care of patients during home dialysis; and administration of medications in patients' homes. Home dialysis staff assistants must meet minimum requirements specified by the Secretary and any State requirements applicable in the State where the staff assistant practices.

The law establishes rather stringent patient eligibility criteria designed to assure that the demonstration is limited to patients whose health problems are exacerbated by travel to a dialysis facility and whose family members are not able to assist them with home dialysis.

Payments to an ESRD provider or dialysis facility participating in the demonstration project are to be prospectively determined by the Secretary, made on a per treatment basis, and paid as an add-on to the dialysis rate. OBRA 1990 provides detailed instructions on calculating the payment rate for staff assistants. The payment structure is designed to prevent duplicate payments for labor costs, since the dialysis rate structure already includes labor costs associated with providing in-facility dialysis.

OBRA 1990 provided funding of $4 million in each of fiscal

years 1991 and 1992 for the demonstration; $3 million in fiscal year 1993; $2 million in fiscal year 1994; and $1 million in fiscal year 1995. The Secretary is directed to submit a preliminary report on the status of the demonstration by December 1, 1992, and a final report by December 31, 1995. The final report is to evaluate the demonstration project and include recommendations regarding eligibility criteria and cost-control mechanisms for providing Medicare coverage of home dialysis aides.

Reimbursement for epoetin.--On June 1, 1989 the U.S. Food and Drug Administration (FDA) approved marketing of a drug used to treat anemia associated with chronic renal failure. The drug, epoetin, is a genetically engineered copy of a protein (erythropoietin or EPO) that the body uses to stimulate production of red blood cells. EPO is used as a substitute for transfusions. Medicare began reimbursing for the drug for chronic renal failure patients with a specified level of anemia in 1989. Chronic renal failure patients may include those not on dialysis or transplant patients as long as they have the specified level of anemia.

In a break with longstanding policy, Medicare's reimbursement rate for EPO was negotiated in advance of FDA approval and was set at about 80 percent of the anticipated market price. Concern about the eventual costs that EPO would add to ESRD expenditures played a major role in HCFA negotiation of a Medicare reimbursement rate below market price.

Reimbursement for the drug varies by the setting in which it is administered. If administered in an approved ESRD

facility (either a hospital or an independent facility), payment is made as an add-on to the dialysis rate. For each administration of the drug of less than 10,000 units, the additional payment was initially set at $40. For patients requiring more than 10,000 units, a payment of $30 was initially made, which was an addition to the $40 payment. The maximum payment was $70.

Physicians receiving monthly capitation payments for providing services to ESRD patients are reimbursed for drug costs but are not given any additional reimbursement for administering the drug. However, they are reimbursed an additional $2 per treatment for supplies, such as syringes. HCFA suggested that reimbursement for actual drug costs be based on drug prices reported in the Drug Topics red book, blue book or Medispan manuals, although, as a matter of practice, some carriers reimburse drug costs based on actual invoices.

Prior to implementing Medicare coverage of EPO, budget estimators had no reliable basis on which to estimate the number of ESRD patients who would use it. HCFA's preliminary estimate was that about 25 percent (25,000 to 30,000) of dialysis patients would use it in the first year of coverage, but that approximately 80 percent (75,000 to 80,000) of dialysis patients would use it by 1994 or 1995. The total yearly costs of providing the drug per user were estimated at $5,600, with Medicare paying $4,480 and the remaining $1,120 paid by other insurers or beneficiaries.

Medicare claims for dialysis patients processed for December 1991 indicate that the dose per treatment averaged about 3,399 units. A total of 75,845 ESRD patients received EPO that month. Medicare payments for EPO in December 1991 were $35.2 million.

OBRA 1990 revised payments made to dialysis facilities

for
EPO by establishing payment rates per 1,000 unit increments;
abolishing the $70 payment cap; and indexing EPO payment rates
for subsequent years. Effective January 1, 1991, payments to
dialysis facilities for EPO were limited to $11 per 1,000 unit
increments, rounded to the nearest 100 units. OBRA 1993
mandated a reduction in EPO payments to $10 per 1,000 units,
rounded to the nearest 100 units (or $1 per 100 units)
effective January 1, 1994.

OBRA 1990 also extended coverage for self-administration of
EPO to home dialysis patients if they are competent to
administer it without medical or other supervision. The
Secretary is to develop methods and standards to determine who
is competent to self-administer the drug. Payments for EPO on
behalf of home dialysis patients who self-administer EPO are
made on the same basis as payments to facilities. This includes
payments to suppliers on behalf of method II patients. Coverage
for self-administration of EPO became effective for services
provided on or after July 1, 1991. OBRA 1993 permitted all
dialysis patients to self-administer EPO.

Medicare spending for ESRD services

Table 5-9 shows overall per capita Medicare spending by
type of ESRD patient from 1986-91. There are four types of ESRD
patients: (1) dialysis patients, (2) transplant patients, (3)
functioning graft (successful transplant) patients, and (4)

graft failure (failed transplant) patients. Dialysis patients are those on dialysis during the year in question. Transplant patients are those who received a transplant during that year. Functioning graft patients are recipients of successful transplants performed during a previous year, and graft failure patients are those who received a transplant during a prior year, but whose transplants failed during the year in question.

Per capita spending for ESRD patients averaged $31,899 in 1991 for patients who had at least 1 full year of Medicare entitlement in the prior year. Thus, these expenditure data exclude patients for whom Medicare was a secondary payer. Spending varied significantly by type of patient. Patients with successful transplants had the lowest average annual expenditures at $7,098, followed by dialysis patients at $35,652. Patients whose transplants failed had higher annual costs at $43,373. The highest costs were reported for patients who had a transplant during the year in question; their 1991 per capita costs were reported at $97,252. If their transplants are successful over the long run, however, these patients are ultimately less expensive to serve because they no longer need either expensive acute care or chronic dialysis services.

TABLE 5-9.--MEDICARE END STAGE RENAL DISEASE PROGRAM EXPENDITURES BY PATIENT TREATMENT GROUP, EXCLUDING MEDICARE SECONDARY PAYER PATIENTS:\1\ 1986-91

Treatment group	1986	1987	1988	1989	1990	1991	Average annual percent change 1986-91
Total number of patients	99,769	108,474	120,431	132,734	145,664	160,805	10.0
Expenditures (per person):							
Total	$24,957	$25,501	$25,852	$27,726	$29,480	$31,899	5.0
Inpatient	11,087	11,190	11,384	12,436	12,989	14,067	4.9
Outpatient	8,999	9,057	8,936	8,927	9,860	10,601	3.3
Physician/supplier	4,737	5,122	5,393	6,192	6,358	6,821	7.6
Other\2\	134	132	139	171	272	410	25.1
Dialysis							
Number of patients	78,228	83,751	92,595	101,816	111,435	122,843	9.4
Expenditures (per patient):							
Total	$26,700	$27,891	$28,674	$31,023	$33,039	$35,652	6.0
Inpatient	10,443	10,890	11,403	12,712	13,198	14,098	6.2

Outpatient					10,810	
11,040	10,946	10,967	12,165	13,133	4.0	
Physician/supplier					5,296	
5,812	6,167	7,148	7,361	7,942	8.4	
Other\2\					152	
149	159	196	315	480	25.9	
			Transplant			
Number of patients					3,876	
3,729	3,767	3,768	4,351	4,648	3.7	
Expenditures:						
Total					$68,036	
$70,559	$71,334	$75,892	$81,339	$97,252	7.4	
Inpatient					51,731	
53,128	52,899	56,586	61,236	75,697	7.9	
Outpatient					8,270	
8,597	8,905	8,890	9,695	10,365	4.6	
Physician/supplier					7,936	
8,731	9,412	10,292	10,274	10,897	6.5	
Other\2\					99	
104	117	124	193	293	24.2	
			Functioning Graft			
Number of patients					16,627	
19,721	22,720	25,524	28,260	31,623	13.7	
Expenditures:						
Total					$6,160	
$6,184	$6,124	$6,697	$6,885	$7,098	2.9	
Inpatient					4,120	
3,935	3,800	4,119	4,201	4,319	0.9	
Outpatient					694	
754	780	829	826	842	3.9	
Physician/supplier					1,287	

1,431	1,480	1,671	1,736	1,778	6.7
Other\2\					
65	65	78	122	159	21.9

Graft Failure

Number of patients					
1,273	1,349	1,626	1,618	1,691	10.3
Expenditures:					
Total					
$35,541	$37,415	$39,739	$39,330	$43,373	5.1

Inpatient					
20,534	21,898	23,398	22,324	24,722	5.0
Outpatient					
8,572	8,476	8,390	9,304	9,810	3.4
Physician/supplier					
6,333	6,932	7,806	7,541	8,538	7.6
Other\2\					
103	109	145	161	303	13.5

\1\Expenditures were calculated only for persons who had at least one full year of Medicare entitlement prior to the observation year. Thus, any patients for whom Medicare was a secondary payer were not included.
\2\Other includes skilled nursing facility and home health services.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Program Management and Medical Information System, and the Medicare Automated Data Retrieval System, April 1992 update, 1986-91.

HOME HEALTH

The hospital insurance (part A) and the supplementary medical insurance (part B) programs cover home health

visits for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy. Persons must also be homebound. The home health benefit is not subject to deductibles or copayments. When an individual is covered under parts A and B of the Medicare program, the individual will generally receive payment for home health services under part A of the program. In 1992, Medicare covered an average of 57 home health visits for persons who qualified for the benefit.

Beginning in 1990, the Medicare home health benefit became again one of the fastest growing parts of the Medicare program. In 1990, reimbursements for home health increased by 49 percent, and in 1993, they increased by 36 percent. As table 10 indicates, home health payments are projected to increase significantly through at least 1996.

Reimbursement to home health agencies is based on Medicare rules for reasonable cost reimbursement. However, home health agencies are required to use the cost per visit by type of service for apportioning costs. Under this method, the total allowable costs of all visits for each type of service (skilled nursing, home health aide, etc.) is divided by the total number of visits by type of service. These average cost per visit amounts are multiplied by the number of covered Medicare visits for each type of service. The products represent the cost Medicare will recognize by type of service, subject to home health agency cost limits.

In 1986, Public Law 99-509 established the current

methodology for determining home health care limits. These are set at 112 percent of the mean of the labor-related and nonlabor per unit costs for each type of service provided by freestanding home health agencies. The limits are then applied on an aggregate basis to all the visits made by the agency, with appropriate adjustments for the special costs of hospital-based agencies.

As a result of OBRA 1993 cost limits applicable to home health services will not be updated for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. In addition, additional payments for the administrative cost of hospital-based home health agencies will be eliminated for cost reporting periods beginning after fiscal year 1993.

TABLE 5-10.--TOTAL MEDICARE HOME HEALTH BENEFIT PAYMENTS\1\

[In millions of dollars]

Fiscal year	Reimbursements			Change from prior year	Visits per 1,000 enrollees\2\	Average charge per visit\2\
	Part A	Part B	Total			
1969	NA	NA	$69	.....	232	$13

1970						NA
NA	82	18.8	222	14		
1971						NA
NA	78	-4.9	164	16		
1972						NA
NA	82	5.1	168	17		
1973						NA
NA	89	8.5	189	18		
1974						NA
NA	147	65.2	211	21		
1975						NA
NA	208	41.5	271	24		
1976						NA
NA	331	59.1	347	27		
1977						NA
NA	429	29.6	419	29		
1978						NA
NA	529	23.3	464	32		
1979						NA
NA	628	18.7	515	34		
1980						NA
NA	756	20.4	577	36		
1981						NA
NA	889	17.6	713	40		
1982						NA
NA	1,167	31.3	1,024	44		
1983						NA
NA	1,480	26.8	1,227	47		
1984						NA
NA	1,744	17.8	1,344	50		
1985						$1,908
$40	1,948	11.7	1,329	55		
1986						1,939
32	1,971	1.2	1,256	58		
1987						1,815
35	1,850	-6.1	1,153	61		
1988						2,010
46	2,056	11.1	1,144	64		
1989						2,251
56	2,307	12.2	1,313	64		
1990						3,352

75	3,427	48.5	1,889	64	
1991					4,995
62	5,057	47.6	2,219	69	
1992					6,986
75	7,061	39.6	3,717	59	
1993					9,529
101	9,630	36.4	4,660	61	
1994					12,533
121	12,654	31.4	5,702	63	
1995					15,074
140	15,214	20.2	6,446	65	
1996					17,217
162	17,379	14.2	6,898	68	
1997					19,127
188	19,315	11.1	7,045	72	
1998					20,518
217	20,735	7.4	7,108	76	
1999					21,932
250	22,182	7.0	7,166	79	

\1\Based on fiscal year 1995 President's budget assumptions. HCFA revises historical estimates slightly with the added data available each year.

\2\Based on Part A alone.

NA=Not available.

Source: Health Care Financing Administration, Division of Budget.

HOSPICE CARE

Public Law 97-248 authorized Medicare part A coverage for hospice care services provided to individuals who are entitled to Medicare part A benefits and who are certified to be terminally ill. In 1986, the Congress in Public Law 99-272 made

the hospice benefit a permanent part of the Medicare program effective April 7, 1986.

On December 16, 1983, the Health Care Financing Administration (HCFA), published regulations to implement the hospice provisions of Public Law 97-248. Among other things, the regulations establish requirements for eligibility, covered benefits, services, reimbursement procedures, and the conditions a hospice must meet to be approved for participation in the Medicare program.

Part A beneficiaries may elect to receive hospice care in lieu of most other Medicare benefits for up to two periods of 90 days each, a subsequent period of 30 days, and an additional extension period if elected.

The statute provides that payment to hospice providers be equal to the costs which are reasonable and related to the cost of providing hospice care, or which are based on such other tests of reasonableness as the Secretary may prescribe, subject to a ``cap amount.'' The cap amount for a beneficiary for a year was established at $6,500, adjusted annually by the medical component of the CPI. The cap for the period November 1, 1992 through October 31, 1993 is $12,248.

HCFA has implemented a prospective payment methodology for hospice care. Under this methodology, hospices are paid one of four predetermined rates for each day a Medicare beneficiary is under the care of the hospice. The rates vary according to the

level of care furnished to the beneficiary. Total reimbursement to a hospice for care furnished to the Medicare beneficiary will vary by the length of the patient's period in the hospice program as well as by the characteristics of the services (intensity and site) furnished to the beneficiary.

Four basic payment categories are used for reimbursing hospices. The payment rates are national rates which are adjusted by the Bureau of Labor Statistics wage index for an area. The published payment rates are:

(a) Routine home care day.--Routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The routine home care rate is paid for every day a patient is at home and under the care of the hospice regardless of the volume or intensity of the services provided on any given day as long as less than 8 hours of care are provided. Currently, this rate is $88.65.

(b) Continuous home care day.--A continuous home care day is a day on which an individual who has elected to receive hospice care receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is furnished only during brief periods of

crisis and only as necessary to maintain the terminally ill patient at home. Home care must be provided for a period of at least 8 hours before it would be considered to fall within the category of continuous home care. Payment for continuous home care will vary depending on the number of hours of continuous services provided. Currently this rate is $517.43 for 24 hours or $21.56 per hour.

(c) Inpatient respite care day.--An inpatient respite care day is one on which the individual who has elected hospice care receives care in an approved facility on a short-term (not more than 5 days at a time) basis for the respite of his caretakers. Currently this rate is $91.70.

(d) General inpatient care day.--A general inpatient care day is one on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. Care may be provided in a hospital, skilled nursing facility or inpatient unit of a freestanding hospice. Currently this rate is $394.39.

Public Law 101-239 required that the payment rates be increased by the hospital market basket percentage increase each fiscal year. As a result of OBRA 1993 the payment

rates
will be increased by the hospital market basket percentage increase minus 2.0 percentage points in fiscal year 1994, market basket minus 1.5 percentage points in fiscal years 1995
and 1996, and market basket minus 0.5 percentage points in fiscal year 1997.

TABLE 5-11.--ESTIMATES OF HOSPICE PROGRAM DATA

	Admissions	Days per admission	Cost per day	Cost per hospice admission	Total cost (outlays in millions)
Fiscal year:					
1984	2,200	29	$62	$1,800	$4
1985	11,000	33	66	2,200	34
1986	28,012	37	66	2,442	68
1987	68,721	41	74	3,034	104
1988	84,770	44	74	3,256	137
1989	89,008	48	74	3,552	211
1990	105,209	60	85	5,100	318
1991	122,179	61	93	5,686	479

1992				
131,041	62	97	6,033	808
1993				
153,490	62	101	6,281	958
1994				
171,589	64	104	8,885	1,138
1995				
192,185	64	107	6,880	1,341
1996				
217,123	64	111	7,090	1,538
1997				
244,331	64	115	7,357	1,758
1998				
271,484	64	120	7,669	1,997
1999				
298,423	65	125	8,119	2,248

Note: Fiscal year 1984 through fiscal year 1992 are actuals; fiscal year 1993 through fiscal year 1999 are estimates.

Source: CBO estimates.

SKILLED NURSING FACILITY

Medicare's part A hospital insurance program covers 100 days of skilled nursing facility (SNF) care for persons who can demonstrate a need for daily skilled nursing care for a condition related to a prior hospitalization. The first 20 days of SNF care are paid in full by the program. Days 21 through 100 are subject to a copayment of $87 a day in 1994. In 1992 Medicare covered an average of 27.5 days of care for those persons who qualified for the benefit.

In general, SNFs are reimbursed on the basis of reasonable costs subject to certain limits. For SNFs, limits are

applied to the per diem routine service costs (nursing, room and board, administrative, and other overhead) of a facility. Capital-related and ancillary costs, such as physical therapy and drugs, are excluded from the cost limits. Separate limits are established for SNFs on the basis of whether they are freestanding or hospital-based facilities and whether they are located in urban or rural areas. Freestanding SNF cost limits are set at 112 percent of the average per diem labor-related and nonlabor costs. Hospital-based SNF cost limits are set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding limit and 112 percent of the average per diem routine service costs of hospital-based SNFs. OBRA 1993 provides that the per-diem cost limits applied to payment for SNF services will not be changed for cost reporting periods beginning during fiscal years 1994 and 1995. Additional payments for excess overhead costs allocated to hospital-based facilities are eliminated, effective for cost reporting periods beginning on or after October 1, 1993.

Public Law 99-272 established a prospective payment rate system for certain SNFs that elect such payment for cost reporting periods beginning on or after October 1, 1986. SNFs providing less than 1,500 days of care per year to Medicare patients in the preceding year would have the option of being paid a prospective payment rate set at 105 percent of the regional mean for all SNFs in the region. The rate is calculated separately for urban and rural areas and the

prospective per diem rate also reflects wage differences between urban and rural areas within each region. These rates cannot exceed the per diem cost limit that would otherwise be applicable to that facility and cannot exceed its cost limit adjusted for capital costs.

Proprietary skilled nursing facilities (SNFs) receive, in addition to payments for the costs of providing services, a return on equity payment, which provides the investors in the facility a return on their investment equivalent to what they would have earned if they had invested the same amount in specified government securities. SNFs are the only providers still receiving Medicare return on equity payments. OBRA 1993 eliminated Medicare payment to SNFs for return on equity, applicable to portions at cost reporting periods beginning on or after October 1, 1993.

Several important changes occurred in the SNF program during 1988 and 1989. First, in April 1988, HCFA issued a new manual to the carriers that was designed to clarify the SNF eligibility requirements. Increases in monthly SNF outlays and anecdotal information strongly suggested that the manual clarifications increased eligibility. Before this manual was issued, monthly outlays for Medicare SNF's were approximately $60 million per month. By the end of 1988, they had risen to almost $100 million per month.

Second, in June 1988 the Medicare Catastrophic Coverage Act of 1988 was enacted. The Medicare catastrophic legislation

(1) removed the requirement that a Medicare beneficiary had to be in the hospital for at least 3 days prior to entering a SNF, (2) instituted a daily coinsurance payment in 1989 of $25.50 for the first 8 days (formerly no copayments were required for the first 20 days), (3) eliminated the coinsurance a beneficiary would have to pay after 8 days (formerly copayments of one-eighth of the hospital deductible of $70 in 1989 were required for days 21-100), and (4) changed the number of days that a person could receive the benefit from 100 days per spell of illness to 150 days per year. These changes were effective January 1, 1989. Monthly SNF spending rose rapidly from $97 million in January 1989 to $280 million in November 1989. Congress subsequently repealed all the legislative changes made in the SNF benefit when it repealed the Medicare Catastrophic Coverage Act.

TABLE 5-12.--SKILLED NURSING FACILITY DATA

Fiscal year	Number of SNF facilities	Total covered days of care (thousands)	Total interim reimbursement (thousands)	Interim reimbursement per day
1977				

4,461	9,757.7	314,148	32
1978			
4,982	9,231.1	317,472	34
1979			
5,055	8,642.0	329,388	38
1980			
5,155	8,701.0	358,508	41
1981			
5,295	8,678.2	393,939	45
1982			
5,510	8,696.2	425,251	49
1983			
5,760	9,277.4	465,341	50
1984			
6,183	9,546.9	489,722	51
1985			
6,725	9,114.1	509,714	56
1986			
7,065	8,175.6	515,444	63
1987			
7,148	7,501.8	560,521	75
1988			
7,379	11,152.5	857,142	77
1989			
8,201	30,172.9	3,046,642	101
1990			
8,937	23,986.5	1,966,545	82
1991			
10,061	22,368.2	2,253,113	101
1991\1\			
11,309	26,843.9	3,253,306	121

\1\Data are considered preliminary.

Source: Data derived from Medicare Decision Support System (MSS), Current Utilization Series Table 8, 09/30/93 Update.

Table 5-12 shows the impact of the 1989 expansions: the number of participating facilities, covered days of care,

and
total reimbursement all increased in 1989. While covered days
of care and reimbursements have declined since the repeal of
the expansions, they have not returned to their pre-1989
levels. A report of the Office of the Inspector General, DHHS,
points to the continued impact of the revised coverage
guidelines; SNFs reluctance to abandon their decisions to
participate or expand their certified beds after having
invested resources to do so; and high demand for skilled
nursing home care.

DURABLE MEDICAL EQUIPMENT

Current Medicare law does not provide an inclusive definition of durable medical equipment (DME). Section 1861(n)
of the Social Security Act specifies that DME includes ``* * *
iron lungs, oxygen tents, hospital beds, wheelchairs (including
power-operated vehicles) * * * used in a patient's home, including an institution used as his home * * *'' DME also includes ``medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, but
excluding drugs and biologicals)''.\1\ In addition to items specified in the law, a wide variety of DME is covered under
Medicare part B.

\1\Section 1861(m)(5) of the Social Security Act.

CURRENT REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT

Medicare pays for DME on the basis of a fee schedule enacted in the Omnibus Budget Reconciliation Act of 1987. Prior to OBRA 1987, reimbursement for DME was made on the basis of reasonable costs to hospital outpatient departments and other providers, such as skilled nursing facilities, and reasonable charges to other part B suppliers. The fee schedule became effective January 1, 1989.

Under the fee schedule, reimbursement is of the lesser of 80 percent of the actual charge for the item or the fee schedule amount. Within the fee schedule, there are five categories of DME. Each category has separate reimbursement principles, although the principles for some categories are similar. The five categories are as follows: (1) inexpensive or other routinely purchased durable medical equipment, which is defined as equipment costing less than $150 or which is purchased at least 75 percent of the time; (2) items requiring frequent and substantial servicing; (3) customized items, which is defined as equipment constructed or modified substantially to meet the needs of an individual patient; (4) other items of durable medical equipment (frequently referred to as the ``capped rental'' category); and (5) oxygen and oxygen equipment.

In addition to these five categories, prosthetics and orthotics were also included in the DME fee schedule prior to the enactment of the Omnibus Budget Reconciliation Act of 1990. Section 1861(s)(9) of the Social Security Act defines prosthetics and orthotics as ``leg, arm, back and neck braces,

and artificial legs, arms and eyes.'' As with DME, this definition is not inclusive.

OBRA 1990 established reimbursement principles for prosthetics and orthotics under a separate section of law. Although a new section of law was created for prosthetics and orthotics, the reimbursement principles established remained identical to those under the DME fee schedule, except that prosthetics and orthotics were exempted from the DME reimbursement changes made in OBRA 1990. (The following discussion of DME reimbursement principles includes prosthetics and orthotics.)

Table 5-13 shows total Medicare allowed payment amounts for DME in calendar year 1992.

TABLE 5-13.--ALLOWED AMOUNTS FOR SELECTED DURABLE MEDICAL EQUIPMENT (DME) CALENDAR YEAR 1991 AND 1992

[In millions of dollars]

Allowed amounts		
Category	1991	1992
Capped rental\1\	$461	$468
Customized items\2\	7	9
Oxygen\3\	739	1,093
Prosthetics/orthotics\4\	553	785
Inexpensive/routinely purchased\5\		

137 181
Items requiring frequent maintenance\6\.....
144 181
Other\7\.....
349 135

Total.....
2,390 2,856

\1\Items of DME on a monthly rental basis not to exceed a period of continuous use of 15 months.

\2\Items unsuitable for grouping together for profiling due to unique nature (custom fabrication, etc.). Payment based on individual adjudication. Amount is incomplete because it only represents HCPCS E1220. Other items are not coded in HCPCS.

\3\Oxygen and oxygen equipment paid based on a monthly rate per beneficiary. Payment not made for purchased equipment except where installment payments continue.

\4\These items include other prosthetic and orthotic devices (except for items included in the categories ``Customized Items'' and ``Items Requiring Frequent Maintenance,'' transcutaneous electrical nerve stimulators, parenteral/enteral nutritional supplies and equipment, and intraocular lenses). Devices in this category paid on lump sum purchase basis.

\5\Inexpensive defined as equipment for which the purchase price does not exceed $150. Routinely Purchased defined as equipment that is

acquired 75 percent of the time by purchase.
\6\Paid on a rental basis until medical necessity ends.
\7\This category includes medical and surgical supplies, additional
ostomy supplies, enteral formulae and enteral medical supplies,
orthotic devices, and vision services which were reported using
procedure codes (e.g., temporary codes and local codes) not included
on the list of codes for categories 1-6 (above) provided by the Health
Care Financing Administration (HCFA), Bureau of Policy Development.

Source: Health Care Financing Administration (HCFA), Bureau of Data
Management and Strategy. Data from the part B Medicare Annual Data
System. Codes for the categories above provided by HCFA, Bureau of
Policy Development, OSDM, DPPS.

CHART 5-1. MEDICARE REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT

Prosthetics and orthotics	Oxygen and oxygen equipment	Inexpensive or routinely purchased DME	Other items of DME	Items requiring frequent and substantial servicing
Customized items	(capped rental)			

Examples of items...	Commode chairs, Hospital beds, electric heat pads, wheelchairs adapted and various types IV poles, bed rails, vaporizers, individual.	Ventilators, Artificial limbs, Liquid and gaseous internal positive infusion pumps, ostomy supplies. pressure breathing specifically for an walkers, of oxygen (IPPB) machines, wheelchairs equipment.		
	blood glucose monitors, pacemaker monitors, seat lift chairs.	ventilators, (including power- excluding driven chairs). ventilators that are either continous airway pressure devices or intermittent assist devices with continuous airway pressure devices.		
Fee schedule basis..	Average charge for purchase or rental. prices on assigned claims, reduced by the percentage by	Average reasonable charge for individual basis.	Determined by the carrier on an	Average of purchase Average reasonable charge. Average reasonable charge for purchase. purchase.

which averge

charges is lower

than average

purchase prices.
National floors and Floor = 85% of Floor = 85% of
No..... Floor = 85% of Floor = 85% of
Floor = 85% of the
ceilings. median of local median of
local median of local
average of national median of all local
payment amounts; payment
amounts; payment amounts;
purchase prices; monthly payment
ceiling = 100% of ceiling = 100%
of ceiling = 100% of ceiling
= 125% of rates; ceiling =
same. Effective: same.
Effective: same. Effective:
same. Effective: 100% of same.
1994. 1994.
1994. 1992. Subsequent Effective 1994.

year: limits are

90% and 120%.
1993 update..... CPI-U..... CPI-
U..... Not applicable..... CPI-
U..... CPI-U..... CPI-U
1994 update..... 0.....
0..... Not applicable.....
0..... 0..... 0
Other provisions.... ..... Reasonable
lifetime. ..... Reasonable
lifetime; ....

limit on rental

payments = 120% of

purchase price.
Base period..... July 1, 1986 to June July 1, 1986 to June Not applicable..... Base period for July 1, 1986 to June Jan. 1, 1986 to Dec.
30, 1987, updated 30, 1987, updated purchase prices-- 30, 1987. 30, 1986, reduced
by the CPI-U to by the CPI-U to July 1, 1986 to
by 5%, and updated
Dec. 1987. Dec. 1987. Dec. 30, 1986, by the CPI-U to

updated by the CPI- Dec. 1987.

U to Dec. 1987.

Base period for

reasonable charges--

Apr. 1, 1988--Dec.

31, 1988.
Rent or purchase.... Rental or purchase.. Rental only..... Purchase only..... Rental with option Purchase only..... Not applicable--

to purchase in monthly payment

first month for amount made.

power-driven

chairs; for other

items, option to

purchase is offered

in the 10th

continuous rental

month.
Regional or national Phased-in national Phased-in national Not applicable..... Phased-in national Phased-in regional Phased-in national
 limits. limits, beginning limits, beginning limits, beginning limits beginning in limits beginning in
 in 1991 and fully in 1991 and fully in 1991 and fully 1992 and fully 1991 and fully
 implemented in 1993. implemented in 1993. implemented in 1993. implemented in implemented in

1994. Effective 1993.

January 1, 1994

national limits

would apply to

ostomy supplies,

trachestomy

supplies and

urologicals.

Medicare law specifies detailed reimbursement principles for DME.\2\ Chart 5-1 gives examples of each category of

equipment, shows the key components of the fee schedule, and describes how these components affect each category of equipment. The following discussion provides more explanation about these components.

\2\The DME fee schedule is contained in section 1834(a) of the Social Security Act; reimbursement principles for prosthetics and orthotics are specified in section 1834(h).

Fee schedule basis

The basis for determining the fee schedule is established in law for each type of equipment. For items requiring frequent and substantial servicing, prosthetics and orthotics, and oxygen and oxygen equipment, the average Medicare reasonable charge is the basis from which fee schedules payments are calculated. Under reasonable charge reimbursement, payment is set at the lowest of the actual charge, the customary charge, the prevailing charge in the locality, or the inflation indexed charge (IIC) for that item.

For customized items, carriers are permitted to determine the appropriate payment amount without regard to average or reasonable charges.

The fee schedule basis for ``capped rental'' equipment is more complicated than for other categories. Originally, the basis for determining fee schedule payments for capped

rental
equipment was the average of submitted purchase prices on assigned claims during the base period.\3\ OBRA 1990 altered
this provision by setting the basis equal to the average of the
purchase prices submitted for assigned claims submitted during
the base time period, increased by the update factor, minus the
percentage by which the average of the reasonable charges for
submitted claims is lower than the average of purchase prices
submitted for items during the last 9 months of 1988.

\3\In the case of assigned claims, the supplier agrees to accept 80
percent of the Medicare fee schedule payment as payment in full. The
beneficiary is liable for 20 percent coinsurance, but not for any
amount by which the supplier's charge exceeds the fee schedule amount.

Implementation of this provision was originally slated for
January 1, 1991, but was delayed until June 1991 because of questions about the validity of claims data. Payment limits were implemented retroactively to May 1, 1991. This provision
was included in OBRA 1990 because of Congressional concerns that the fee schedule basis for capped rental items was too high and thus resulted in excessive Medicare payments for these
items.

Base time period

Current law specifies the time period used to calculate the basis of the fee schedule for each category of equipment. The most common base period is from July 1, 1986 to June 30, 1987, updated by the Consumer Price Index for Urban consumers (CPI-U) to December 1987.

Rental or purchase

Some categories of DME may only be rented, some may only be purchased, and some may be either rented or purchased. Inexpensive or routinely purchased DME may be rented or purchased. Items requiring frequent and substantial servicing must be rented because they need regular maintenance to function properly and avoid risk to beneficiaries' health. Customized items may only be purchased because they are specifically fitted for an individual and cannot be used by anyone else. Since oxygen is a consumable item, it cannot be rented. Medicare does not reimburse for purchase of oxygen equipment; rental for equipment is included in the monthly payment for oxygen.

Other items of DME are rented with an option to purchase at different times, depending on the equipment. For power-driven wheelchairs, beneficiaries are given the option to purchase in the first month of rental. If beneficiaries exercise the option to purchase power-driven wheelchairs, payment for purchase is made on a lump-sum basis. For other items in this category, beneficiaries are given the option to purchase in the tenth month of continuous rental. If beneficiaries opt to purchase,

title is transferred to them after the thirteenth month of continuous rental.\4\ For all items in this category of DME, reimbursement for rental is limited to 15 continuous months.

\4\The same cycle of payments for maintenance and servicing applies to both rented and purchased equipment in this category.

Regional or national limits on payment

Beginning in 1993, most categories of DME are subject to national limits on payments. The national limits replace regional limits enacted in OBRA 1987.

Customized items and prosthetics and orthotics are generally not subject to these limits. Customized items are not subject to any payment limits, while prosthetics and orthotics are subject to regional payment limits, beginning in 1992, and fully implemented in 1994. OBRA 1993, however, imposed national limits on ostomy supplies, tracheostomy supplies and urologicals effective January 1, 1994.

Payment floors and ceilings

The national limits on payments contain upper and lower limits (referred to as ceilings and floors) on payments. The ceiling was originally equal to 100 percent of the weighted average of local payment amounts and the floor is equal to 85 percent of the weighted average of local payment amounts. These

limits took effect in 1991. OBRA 1993 changed the basis for the ceilings and floor to median effective January 1, 1994.

The floors and ceilings applied to the regional payment limits for prosthetics and orthotics vary somewhat from those used for national payment limits. The limits did not take effect until 1992. In 1992, the floor for prosthetics and orthotics was the same--85 percent of the weighted average of the local payment amount, but the ceiling is higher--125 percent of the weighted average. In addition, the limits differ in 1993 and subsequent years, when they are set at 90 and 120 percent of the weighted average of local payment amounts.

Update to the fee schedule

The 1994 fee schedule update for most categories of DME was the CPI-U or 3.0 percent. The update is applied to fee schedule payments set during the base period, rather than to more current charge data.

The 1993 payment update for prosthetics and orthotics was the CPI-U or 3.0 percent. As a result of OBRA 1993 prosthetics and orthotics will not receive an update in 1994 and 1995. One piece of prosthetic and orthotic equipment, a transcutaneous electrical nerve stimulator (TENS), was subject to a 15-percent reduction in fee schedule payments from April 1, 1990, through December 30, 1990. TENS devices were subjected to an additional 15 percent reduction in 1991. OBRA 1993 reduced payment by an

additional 30 percent effective January 1, 1994.

Other provisions

Useful lifetime for rental items.--As enacted in OBRA 1987, payment for categories of equipment that could only be rented was made on a monthly basis. In the case of items requiring frequent and substantial servicing, monthly rental payments continued as long as the equipment was needed. In the case of capped rental items, monthly payments were made for 15 months, after which one payment was made every subsequent 6 months for maintenance and servicing of the item. In both cases, no provision was made for replacement of the item.

OBRA 1990 permitted the Secretary to establish a useful lifetime for these types of equipment, and to establish a new cycle of monthly payments for capped rental items. A useful lifetime of 5 years was established, unless the Secretary determines that 5 years is not appropriate for an individual item. In that case, the Secretary is to establish an alternative reasonable lifetime. When the reasonable lifetime has been reached, or the carrier determines that an item is lost or irreparably damaged, the item is replaced.

Limitation on payment amounts for capped rental items.-- Prior to OBRA 1990, monthly payments for capped rental items were made for a 15-month period, with total payments for an item limited to 150 percent of the purchase price. Each monthly payment was equal to 10 percent of the purchase price. OBRA 1990 limited monthly rental payments for these items to 120 percent of the purchase price, with monthly payments equal to

10 percent of the purchase price for the first 3 months, and
7.5 percent of the purchase price for the next 12 months.

ADMINISTRATION OF THE FEE SCHEDULE

Consolidation of administration

On June 18, 1992, the Health Care Financing Administration (HCFA) published a final rule regarding DME claims payments. The rule establishes four regional carriers to process all claims for DME and prosthetics and orthotics. HCFA argues that, as a result of this consolidation, greater efficiency in claims processing will be achieved, and variance in coverage policy and utilization parameters will be greatly reduced.

In addition, the rule also requires that the responsibility for processing claims for beneficiaries residing within each regional area would be allocated to the regional carrier for that area. This change will eliminate the ability of suppliers to engage in ``carrier shopping,'' that is, filing claims in those carrier areas that have higher payment rates.

Consolidation of claims processing for DME and prosthetics and orthotics was phased in beginning October 1, 1993 and is scheduled to be completed by July 1, 1994. The process will be on a state-by-state basis with the larger States being incorporated into the system during the final stages.

The rule also proposes minimum standards that suppliers must meet before obtaining a Medicare billing number. A

supplier must receive and fill orders from its own inventory or inventory in other companies with which it has contracted to fill such orders. In addition, a supplier must be responsible for delivering Medicare covered items to beneficiaries, honoring any warranties, answering any questions or complaints the beneficiaries might have, maintaining and repairing rental items and accepting returns of substandard or unsuitable items from beneficiaries.

Overused items

OBRA 1990 required the Secretary to develop a list of DME items frequently subject to unnecessary utilization; the list must include seat-lift mechanisms; transcutaneous electrical nerve stimulators (TENS); and motorized scooters. Carriers are directed to determine, in advance, whether payment will be made for items on the Secretary's list. Thus, DME suppliers must obtain carriers' approval before providing items on the list to Medicare beneficiaries.

Certificates of medical necessity

All DME must be prescribed by a physician in order to be reimbursed by Medicare. Instead of a physician's prescription, carriers may require completion of a certificate of medical necessity (CMN) to document that an item is reasonable and medically necessary. OBRA 1990 prohibited DME suppliers

from
distributing completed or partially completed CMNs and
established penalties for suppliers who knowingly and
willfully
distribute forms in violation of the prohibition.
    The purpose of this provision was to prohibit DME
suppliers
from directly marketing DME items to Medicare beneficiaries
by
providing them with completed CMNs for them to submit to
their
physicians. Requiring physicians to complete CMNs will also
encourage them to take a more active role in considering
their
patients' needs for DME, while simultaneously reducing DME
suppliers' ability to influence DME acquisition.
    This provision was to be implemented January 1, 1991,
but
was not implemented until December 1991 because of
administrative difficulties.

Inherent reasonableness

    The Secretary is permitted to increase or decrease
Medicare
payments in cases where the payment amount is ``*9*9*
grossly
excessive or grossly deficient and not inherently
reasonable.''
The Secretary's authority to make these payment adjustments
is
generally referred to as inherent reasonableness authority.
    In order to make a payment adjustment, the Secretary
must
demonstrate that the payment meets several criteria of
inherent
reasonableness specified by law. In addition, the Secretary
must publish a notice in the Federal Register outlining his
proposal to reduce or increase payment amounts, the
proposed
methodology for adjusting the payment amount, and the

potential
impact of the payment adjustment. The Secretary is also required to provide a 60-day public comment period and to publish a final determination in the Federal Register. The final determination must include an explanation of the factors
and data the Secretary took into consideration in making the
determination.

According to HCFA, the Secretary rarely uses inherent reasonableness authority because the requirements are too stringent and the notice requirements too burdensome to permit
easy imposition of inherent reasonableness adjustments. Moreover, the Secretary was prohibited, by law, from making inherent reasonableness adjustments to the DME fee schedule prior to January 1, 1991.

MEDICARE PAYMENTS FOR SERVICES IN HOSPITAL OUTPATIENT DEPARTMENTS

Medicare outpatient hospital services are reimbursed under
Medicare part B. Services provided in outpatient hospital settings and included in expenditure data for this service setting are: emergency room services, clinic, laboratory, radiology, pharmacy, physical therapy, ambulance, operating room services, end stage renal disease services, durable medical equipment, and other services such as computer axial
tomography and blood. Services rendered by physicians in outpatient hospital settings are not included in these expenditure data.

Prior to 1983, hospital outpatient services, excluding physicians' services, were paid for on a reasonable cost basis.
Some services, such as emergency services, are still reimbursed
on a reasonable cost basis. However, Congress has enacted a number of provisions that have altered the ways hospital outpatient departments are paid for their services and

placed
limits on others. For example, outpatient dialysis services are
paid on the basis of a fixed composite rate; clinical
laboratory services are paid on the basis of a fee schedule; x-
ray services are subject to a limit on payments; and ambulatory
surgical facility fees for surgeries performed in hospital
outpatient departments are based on a weighted average of the
hospital's costs and the prevailing fee that would be paid to a
free-standing ambulatory surgical facility in the area.

Payments for services delivered in outpatient hospitals were $9.7 billion in calendar year 1992. Payments to outpatient hospitals constituted approximately 20 percent of all Medicare part B payments in 1992 and about 8 percent of total Medicare payments (parts A and B). Table 5-14 provides information on the number of part B enrollees, covered charges, aggregate reimbursements and reimbursements per enrollee for hospital outpatient services from 1974 to 1992. Table 5-15 shows the percent distribution of Medicare hospital outpatient charges, by type of service for 1992.

TABLE 5-14.--MEDICARE HOSPITAL OUTPATIENT CHARGES AND REIMBURSEMENT BY TYPE OF ENROLLMENT AND YEAR SERVICE INCURRED: SELECTED YEARS 1974-92

Type of enrollment and year of service	Number of SMI \1\	Covered	Program payments

enrollees in thousands	charges in thousands	Amount in thousands	Per enrollee	Percent of charges
All beneficiaries:				
1974				
23,166,570	$535,296	$323,383	$14	60.4
1976				
24,614,402	974,708	630,323	26	64.7
1978				
26,074,085	1,384,067	923,658	35	66.7
1980				
27,399,658	2,076,396	1,441,986	52	69.4
1982				
28,412,282	3,164,530	2,203,260	78	69.6
1984				
29,415,397	5,129,210	3,387,146	115	66.0
1986				
30,589,728	8,115,976	4,881,605	160	60.1
1987				
31,169,960	9,623,763	5,600,094	180	58.2
1988				
31,617,082	11,833,919	6,371,704	201	53.8
1989				
32,098,770	14,195,252	7,160,586	223	50.4
1990				
32,635,800	18,346,471	8,171,088	250	44.5
1991				
33,239,840	22,016,673	8,612,320	259	39.1
1992				
33,956,460	26,209,063	9,703,004	286	37.0
Average annual rate of growth				

1974-89					
2.2	24.4	22.9	20.3	-1.9	
1974-84					
2.4	25.4	26.5	23.4	0.9	
1984-92					
1.8	22.6	14.1	12.1	-7.0	
Aged:					
1974					
21,421,545	394,680	220,742	10	55.9	
1976					
22,445,911	704,569	432,971	19	61.5	
1978					
23,530,893	1,005,467	648,249	28	64.5	
1980					
24,680,432	1,517,183	1,030,896	42	69.9	
1982					
25,706,792	2,402,462	1,645,064	64	68.5	
1984					
26,764,150	4,122,859	2,679,571	100	65.0	
1986					
27,862,737	6,529,273	3,809,992	137	58.4	
1987					
28,382,203	7,859,038	4,436,787	156	56.5	
1988					
28,780,154	9,790,273	5,098,546	177	52.1	
1989					
29,216,027	11,855,127	5,767,589	197	48.6	
1990					
29,691,180	15,384,510	6,563,454	221	42.7	
1991					
30,183,480	18,460,835	6,842,329	227	37.1	
1992					
30,722,080	21,856,012	7,593,513	247	34.7	

Average annual rate of growth

1974-89					

2.1	25.5	24.3	22.0	-0.9	
1974-84					
2.3	26.4	28.4	25.9	1.5	
1984-92					
1.7	23.2	13.9	12.0	-7.5	
Disabled:					
1974					
1,745,019	140,617	102,641	57		70.8
1976					
2,168,467	270,139	197,352	91		73.1
1978					
2,543,162	378,600	275,409	108		72.7
1980					
2,719,226	559,213	411,090	152		73.5
1982					
2,705,490	762,068	558,195	206		73.2
1984					
2,651,247	1,006,351	707,575	267		70.3
1986					
2,726,991	1,586,703	1,071,613	393		67.5
1987					
2,787,757	1,764,726	1,163,307	417		65.9
1988					
2,836,928	2,043,646	1,273,158	449		62.3
1989					
2,882,743	2,340,124	1,392,897	483		59.5
1990					
2,944,620	2,961,961	1,607,634	546		54.0
1991					
3,056,360	3,555,838	1,769,991	579		49.8
1992					
3,234,380	4,353,051	2,109,491	695		48.5

Average annual rate of growth

1974-89				
3.4	20.6	19.0	15.3	-1.2

1974-84.....				
4.3	21.8	21.3	16.7	-0.1
1984-92.....				
2.5	20.1	14.6	12.7	-4.5

\1\1974 is the first full year of coverage for disabled beneficiaries under Medicare.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; Data developed by the Office of Research and Demonstrations.

TABLE 5-15.--PERCENT DISTRIBUTION OF HOSPITAL OUTPATIENT CHARGES UNDER MEDICARE, BY TYPE OF SERVICE, 1992

	Percent of charges
Radiology.....	19.2
Laboratory.....	9.7
Operating room.....	12.6
End stage renal disease.....	9.3
Pharmacy.....	6.8
Emergency room.....	3.5
Clinic.....	1.9
Physical therapy.....	

4.0
Medical supplies.....
9.9
All other\1\.....
23.0

\1\Includes computerized axial tomography, durable medical equipment,
blood, etc.

Source: Health Care Financing Administration, Bureau of Data Management
and Strategy: Data from the Medicare Decision Support System.

From 1984 to 1992, hospital outpatient reimbursements grew
14.6 percent a year.

Recent legislative changes

Capital.--OBRA 1989 reduced payments for capital costs for
outpatient services paid on a reasonable cost basis or a blend
of reasonable costs and charges by 15 percent for portions of
cost-reporting periods beginning in fiscal year 1990. This reduction also applied to capital related to services reimbursed on a blended amount; these services include radiology, diagnostic procedures and outpatient surgery. However, in the case of blends or limits based on blends, the
reduction applied only to the cost portion of the blended amount. Outpatient capital costs of sole community hospitals
were exempt from this reduction.

OBRA 1990 reduced reimbursement for capital costs for outpatient hospital services and the cost portion of outpatient

hospital services paid on the basis of a blended amount for payments attributable to portions of cost-reporting periods occurring during fiscal year 1991 by 15 percent. These payments will be reduced by 10 percent for portions of cost-reporting periods occurring during fiscal years 1992, 1993, 1994, and 1995. Sole community hospitals and rural primary care hospitals are exempt from these reductions. OBRA 1993 extended the 10 percent reduction through fiscal year 1998.

Services paid on a cost-related basis.--OBRA 1990 also reduced payment for services paid on a cost-related basis, other than capital costs, by 5.8 percent of the recognized costs for payments attributable to cost-reporting periods occurring during fiscal years 1991, 1992, 1993, 1994, and 1995. The reduction is also applied to cost portions of blended payment limits for ambulatory surgery and radiology services. Sole community hospitals and rural primary care hospitals are exempt from the reduction. OBRA 1993 extended the 5.8 percent reduction through fiscal year 1998.

Prospective payment proposal.--OBRA 1990 also directed the Secretary to develop a proposal to replace the current payment system for hospital outpatient services with a prospective payment system. The Secretary is to consider the following factors in developing the proposal: (1) the need to provide for appropriate limits on increases in Medicare expenditures; (2) the need to adjust prospectively determined rates to account for changes in a hospital's outpatient case mix; (3) providing hospitals with incentives to control the costs of providing outpatient services; (4) the feasibility and

appropriateness of including payment for outpatient services not currently paid on a cost-related basis under Medicare (including clinical diagnostic laboratory tests and dialysis services) in the system; (5) the need to increase payments to hospitals that treat a disproportionate share of low-income patients; teaching hospitals; and hospitals located in geographic areas with high wages and wage-related costs; (6) the feasibility and appropriateness of bundling services into larger units, such as episodes or visits, in establishing the basic unit for making payments under the system; and (7) the feasibility and appropriateness of varying payments on the basis of whether services are provided in a freestanding or hospital-based facility.

The law also required the Administrator of Health Care Financing Administration to submit research findings regarding prospective payments for hospital outpatient services to specified committees of Congress by January 1, 1991. The Secretary was directed to submit his proposal to Congress by September 1, 1991. As of January 1994, that report had not been submitted to Congress. The Prospective Payment Assessment Commission (ProPAC) was to submit its analysis and comments on the proposal by March 1, 1992. ProPAC recommended implementation of a prospective payment system for all providers of outpatient services, including hospitals, physicians' office-based services, and freestanding ambulatory surgical centers. The Commission also recommended adjusting the payment rate to reflect justifiable cost differences such as wages and case mix.

Eye and eye and ear specialty hospitals.--OBRA 1990 also changed the reimbursement blend for ambulatory surgery services provided in eye, and eye and ear specialty hospitals meeting specified conditions. Prior to OBRA 1990, payment for these services was based on a blend that consists of 75 percent of the hospital's costs and 25 percent of the applicable freestanding ambulatory surgical center rate. However, the blend was scheduled to change to 50/50 for cost-reporting periods beginning after fiscal year 1990. OBRA 1990 extended use of the 75/25 blend to services provided in cost-reporting years beginning before January 1, 1995.

UTILIZATION AND QUALITY CONTROL PEER REVIEW PROGRAM

The Medicare utilization and quality control peer review organization program was established by Congress under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 97-35). Building on the former professional standards review organizations, the new peer review organizations (PROs) were charged by the 1982 law with reviewing services furnished to Medicare beneficiaries to determine if the services met professionally recognized standards of care and were medically necessary and delivered in the most appropriate setting. Major changes were made to the PRO program by the Social Security Act Amendments of 1983 (P.L. 98-21) and subsequent budget reconciliation acts. Most PRO review is focused on

inpatient hospital care. However, there is limited PRO review of ambulatory surgery, postacute care, and services received from Medicare HMOs.

There are currently 53 PRO areas, incorporating the 50 States, Puerto Rico, and the territories. Organizations eligible to become PROs include physician-sponsored and physician-access organizations. In limited circumstances, Medicare fiscal intermediaries may also be eligible. Physician-sponsored organizations are composed of a substantial number of licensed physicians practicing in the PRO review area (e.g., a medical society); physician access organizations are those which have available to them sufficient numbers of licensed physicians so that adequate review of medical services can be assured. Such organizations obtain PRO contracts from the Secretary of HHS, through a competitive proposal process. Each organization's proposal is evaluated by HCFA for technical merit using specific criteria that are quantitatively valued. Priority is given to physician-sponsored organizations in the evaluation process. By October 1993, all 53 PROs were operating under the fourth round of contracts (also referred to as the ``fourth scope of work'').

In general, each PRO has a medical director and a staff of nurse reviewers (usually registered nurses), data technicians, and other support staff. In addition, each PRO has a board of directors, comprised of physicians and, generally, representatives from the State medical society, hospital association, and State medical specialty societies. OBRA

1986 (P.L. 99-509) requires each board to have a consumer representative. Because the board is usually consulted before a case is referred by the PRO to the HHS inspector general for sanction, it assumes a major role in the PRO review process.

Each PRO also has physician advisors who are consulted on cases in which there is a question regarding the nurse reviewer's referral. Only physician advisors can make initial determinations about services furnished or proposed to be furnished by another physician.

PROs are paid by Medicare on a cost basis for their review work. Spending for the PROs in fiscal year 1993 totaled $214 million; in 1994, spending is expected to be $325 million. (Spending varies considerably from year to year depending on where the PROs are in their contract cycles. HCFA projections for fiscal year 1995 are $218 million.) Funds for the PRO program are apportioned each year from the Medicare HI and SMI trust funds in an amount that is supposed to be sufficient to finance PRO program requirements. This is the same manner as transfers are made for payment of Medicare services provided directly to beneficiaries. HCFA is bound by law to follow the apportionments in the running of the PRO program; as such, the apportionments determine contract specifications and serve as a device to control spending.

The PRO review process combines both utilization and quality review. In conducting utilization review, the PRO

checks that the services provided to a Medicare patient were necessary, reasonable, and appropriate to the setting in which they are provided. Although some utilization review is done on a prospective basis, the bulk of the reviews are done retrospectively, i.e., after the hospitalization has occurred. When a PRO determines that the services provided were unnecessary or inappropriate (or both), it issues a payment denial notice. The provider(s), physician(s), and the patient are given an opportunity to request reconsideration of the determination.

In general, the PRO checks for indications of poor quality of care as it is conducting utilization review. If a PRO reviewer detects a possible problem, then further inquiry is made into the case. If it is determined that the care was of poor quality, the PRO must take steps to correct the problem. Specific sanctions are required if the PRO determines that the care was grossly substandard or if the PRO has found that the provider or the physician has a pattern of substandard care. In addition, under section 9403 of COBRA (P.L. 99-272), as amended by P.L. 101-239, authority exists for the PROs to deny payments for substandard quality of care but this provision has not been implemented.

Each of the contracts between HHS and the PROs must contain certain similar elements outlined in a document known as the

Scope of Work. Under the third and previous scopes of work, PRO review was centered on case-by-case examinations of individual medical records, selected primarily on a sample basis, basically using local clinical criteria. This approach to medical review has been criticized by the Institute of Medicine and others as being costly, confrontational, and ineffective.

The fourth scope of work incorporates a new review strategy called the Health Care Quality Improvement Initiative. PROs are required to use explicit, more nationally uniform criteria to examine patterns of care and outcomes using detailed clinical information on providers and patients. Instead of focusing on unusual deficiencies in care, the PROs are instructed to focus on persistent differences between actual indications of care and outcomes from those patterns of care and outcomes considered achievable. HCFA believes that this approach will encourage a continual improvement of medical practice in a way that will be viewed by physicians and providers as educational and not adversarial.

CBO BASELINE MEDICARE PROJECTIONS

The supplementary medical insurance (SMI) baseline is constructed following the Medicare volume performance standard (the standard) guidelines established in OBRA 1989 and amended in OBRA 1990 and OBRA 1993. The standard is a prospectively set

target for growth in physicians' services. Actual growth is then compared to the standard and physicians' fees are adjusted to reflect the difference between the standard and actual growth. For example, the 1990 standard was set at 9.1 percent for all physicians' services. The actual growth in 1990 expenditures for physicians' services was 10.0 percent. Therefore, the 1992 Medicare Economic Index (MEI) was reduced by the difference (0.9 percent) subject to a maximum reduction of 2 percentage points.

For years after 1991, a default process was established to set a standard in the absence of congressional action. A standard was calculated for all physicians' services and for surgical and nonsurgical services separately. Surgical services are defined as surgical services performed by surgical specialists. Nonsurgical services are all other physicians' services including independent laboratory services. If the default becomes the standard, then the update for each category of physicians' services would be adjusted by the difference between growth in expenditures and the standard for each category.

The default standard is the product of (1) the increase in fees for physician services, (2) the increase in average enrollment (or non-HMO enrollees), (3) the average annual increase in the volume and intensity of services for the past 5 years, (4) the percentage increase or decrease caused by legislation or regulation, and (5) 1 minus the standard factor stated in the law. The standard factor is 1.5 percentage points in 1992 and 2 percentage points in 1993.

The 1992 standard was 6.5 percent for surgical

services,
11.2 percent for nonsurgical services, and 10 percent for all
physician services. The 1993 standard was 8.4 percent for
surgical services, 10.8 percent for nonsurgical services and 10
percent for all services.

OBRA 1993 increased the performance standard factor to 3.5
percentage points in fiscal year 1994 and 4 percentage points
thereafter. It also created a new primary care category. The
fiscal year 1994 standard is 8.6 percent for surgical services,
10.5 percent for primary care services, 9.2 percent for other
nonsurgical services, and 9.3 percent for all physicians
services.

TABLE 5-16.--CBO PROJECTIONS FOR MEDICARE PROGRAM COMPONENTS BASELINE

[Outlays by fiscal year, in billions of dollars]

	1993	1994	1995	1996	1997	1998	1999
Medicare Part A: Hospital Insurance (HI)							
Total HI outlays	$91.6	$102.0	$111.8	$120.8	$131.4	$143.1	$156.9
Annual growth rate	.....	11.3	9.6	8.1	8.8	8.9	9.7
Hospitals	74.8	81.0	87.9	94.3	102.2	111.3	122.4
Annual growth rate	.....	8.3	8.5	7.3	8.4	8.9	10.0
PPS hospitals	64.8	69.2	74.5	78.5	83.8	90.1	98.1

Non-PPS hospitals/units.....					10.1
11.9	13.4	15.8	18.4	21.2	24.3
Hospice.....					1.0
1.1	1.3	1.5	1.8	2.1	2.4
Annual growth rate.....					.....
18.5	16.0	16.4	16.8	15.9	16.4
Home health.....					9.5
11.7	13.6	15.3	17.0	18.6	20.3
Annual growth rate.....					.....
23.6	16.5	12.3	11.2	9.5	8.7
Skilled nursing facilities.....					5.3
6.6	7.4	8.1	8.8	9.5	10.1
Annual growth rate.....					.....
24.4	12.4	9.0	8.5	7.6	7.2
Other part A (PROs).....					0.2
0.3	0.2	0.2	0.2	0.2	0.2
Annual growth rate.....					.....
50.0	-33.3	0.0	0.0	0.0	0.0
Administration (subject to appropriation).					0.9
1.2	1.3	1.3	1.4	1.4	1.5
Annual growth rate.....					.....
38.8	5.3	4.8	4.6	4.4	4.3
General part A information					
Indirect teaching payments.....					3.3
3.6	3.9	4.1	4.5	4.8	5.3
Direct medical education payments.....					1.7
1.7	1.8	1.9	2.0	2.2	2.3
Disproportionate share payments.....					3.0
3.3	3.5	3.8	4.1	4.4	4.8
Inpatient capital payments.....					7.7
8.5	9.4	10.3	11.2	12.3	13.4
HI trust fund income.....					97.1
106.6	118.6	125.9	131.7	138.1	143.8
HI trust fund surplus.....					5.5
4.6	6.8	5.1	0.3	-5.0	-13.1
HI trust fund balance (EOY).....					126.1
130.7	137.5	142.5	142.8	137.8	124.7
Other part A information					
HI deductible (in CY dollars).....					$676
$696	$720	$748	$784	$824	$868
Part A FY enrollment (millions).....					35.5

36.1 36.8 37.4 38.0 38.5 39.0
PPS market basket increase FY%..... 4.1
4.3 4.7 4.6 4.3 4.2 4.2
PPS update factor (average)..... 2.7
2.0 2.6 2.6 3.8 4.2 4.2
Monthly premium (in CY dollars)..... $221
$245 $262 $276 $295 $317 $340
Premium receipts (FT billions)..... $0.5
$0.6 $0.7 $0.8 $0.8 $0.9 $1.0

Medicare Part B: Supplementary Medical
Insurance (SMI)
Total SMI outlays..... 54.3
60.9 68.7 77.5 87.5 98.2 110.1
Annual growth rate..... .....
12.2 12.9 12.8 12.9 12.2 12.1
Physicians..... 28.5
30.2 33.4 36.8 40.6 44.3 47.8
Annual growth rate..... .....
6.2 10.7 10.2 10.3 8.9 8.1
DME and P & O suppliers..... 2.2 2.4
2.7 3.0 3.3 3.7 4.0
Annual growth rate..... .....
9.9 11.1 10.7 10.9 9.7 9.0
Laboratories\1\..... 4.2
4.7 5.3 6.0 6.7 7.5 8.4
Annual growth rate..... .....
11.7 12.7 12.4 12.5 12.1 11.9
Outpatient hospital..... 9.6
11.0 12.7 14.8 17.2 19.8 23.1
Annual growth rate..... .....
14.4 15.5 16.3 15.8 15.6 16.6
Other part B..... 7.9
10.8 12.6 14.9 17.7 20.8 24.5
Annual growth rate..... .....
37.4 16.7 18.3 18.4 17.7 17.9
Administration (subject to appropriation). 1.8
1.7 1.9 2.0 2.0 2.1 2.2
Annual growth rate..... .....
-10.2 12.6 4.9 4.6 4.3 4.3
Other part B information

SMI deductible (in dollars).....	$100	$100	$100	$100	$100	$100
MEI update (calendar year).....	2.2	2.3	2.9	2.8	2.7	2.6	2.5
Physician update (calendar year)\2\.....	1.4	9.3	5.2	3.2	1.4	-2.4	-2.5
Laboratory update (calendar year).....	3.0	0.0	0.0	3.0	3.0	3.1	3.1
DME update (calendar year).....	3.1	2.7	2.9	2.9	3.1	3.1	3.1
Premium information							
Monthly premium (in dollars).....	$36.60	$41.10	$46.10	$43.30	$51.00	$57.10	$58.90
Premium receipts (in billions).....	14.7	16.8	19.2	19.0	21.5	24.7	27.8
FY enrollment (in millions).....	34.3	34.9	35.6	36.2	36.7	37.2	37.6
Total medicare disbursements.....	145.9	162.8	180.5	198.3	218.9	241.3	267.1
Total function 570--Medicare (disbursements net of premiums.....	130.7	145.5	160.6	178.5	196.6	215.7	238.3

\1\Laboratory spending reflects services provided in physician offices, outpatient hospital departments and independent laboratories. In previous years the CBO fact sheet has shown spending for independent laboratories only.

\2\Based on the current volume performance standard, we assume an upward adjustment to the MEI in fiscal years 1995 and 1996, and a downward adjustment to the MEI in fiscal years 1997, 1998 and 1999.

Source: Congressional Budget Office.

MEDICARE AS SECONDARY PAYER

Under current law, Medicare is a secondary payer under specified circumstances when beneficiaries are covered by other

third-party payers. Medicare is secondary payer to workers' compensation, automobile, medical, no-fault, and liability insurance.

Medicare is also secondary payer to certain employer health plans covering aged and disabled beneficiaries and for end stage renal disease (ESRD) beneficiaries during the first 18 months of a beneficiary's entitlement to Medicare on the basis of ESRD.

Table 5-17 shows savings attributable to these Medicare secondary payer provisions. In fiscal year 1985, combined Medicare part A and part B savings were $750 million. By fiscal year 1993, the total savings equaled $2.9 billion.

TABLE 5-17.--MEDICARE SAVINGS ATTRIBUTABLE TO SECONDARY PAYER PROVISIONS, BY TYPE OF CIRCUMSTANCE

[In millions of dollars, by fiscal year]

	Working aged	ESRD	Automobile	Disability	Workers compensation	Total
1988:						
Part A	$110.1	$786.7	$88.4	$149.6	$275.5	$1,410.3
Part B	18.1	313.8	20.2	22.3	93.5	467.9
Total	128.2	1,100.5	108.6	171.9	369.0	1,878.2

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1989:
    Part A.............................          99.4
867.7        75.0       179.6       399.3    1,621.0
    Part B.............................          27.5
337.1        25.1        28.2       137.0      554.9

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      Total.............................         126.9
1,204.8       100.1       207.8       536.3    2,175.9

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1990:
    Part A.............................         120.9
981.6       144.1       220.1       498.4    1,965.1
    Part B.............................          21.6
325.8        21.5        26.4       123.2      518.5

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      Total.............................         142.5
1,307.4       165.6       246.5       621.6    2,483.6

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1991:
    Part A.............................         107.4
932.7       144.9       235.6       526.6    1,947.2
    Part B.............................          21.2
417.5        40.2        26.6       186.2      691.7

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      Total.............................         128.6
1,350.2       185.1       262.2       712.8    2,638.9

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1992:
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Part A.....					118.9
1,044.9	140.8	233.9	600.9	2,139.4	
Part B.....					17.3
398.3	37.4	34.5	182.9	670.4	
Total.....					136.2
1,443.2	178.2	268.4	783.8	2,809.8	
1993:					
Part A.....					100.4
1,073.1	133.6	239.6	657.8	2,204.5	
Part B.....					11.3
392.2	32.8	28.9	192.3	657.5	
Total.....					111.7
1,465.3	166.4	268.5	850.1	2,862.0	

Source: Health Care Financing Administration.

FINANCING

Background

The Medicare part A Hospital Insurance Trust Fund (HI) finances inpatient hospital, skilled nursing facility, home health and other institutional services. The part B Supplementary Medical Insurance Trust Fund (SMI) finances principally physician and hospital outpatient services.

The Hospital Insurance Trust Fund is financed primarily through Social Security payroll tax contributions paid by employers, employees and the self-employed. The payroll tax rate for HI for calendar year 1994 is 1.45 percent on all earnings in covered employment. (The OASDI earnings base

for
1994 is $60,600.) An equal contribution rate is paid by the employer. Table 5-18 shows the contribution rates and maximum
taxable earnings for both HI and the old-age, survivors and disability insurance (OASDI) programs.

TABLE 5-18.--CURRENT LAW SOCIAL SECURITY PAYROLL TAX RATES FOR
EMPLOYERS AND EMPLOYEES EACH AND TAXABLE EARNINGS BASES

Calendar year	Employee and employer rates, each (percent)			HI taxable earnings	Maximum HI tax
	OASDI		OASDHl		
	combined	Hl	combined	base	
1977	4.95	0.90	5.85	$16,500	$148.50
1978	5.05	1.10	6.05	17,700	194.70
1979	5.08	1.05	6.13	22,900	240.45
1980	5.08	1.05	6.13	25,900	271.95
1981	5.35	1.30	6.65	29,700	386.10
1982	5.40	1.30	6.70	32,400	421.20
1983	5.40	1.30	6.70	35,700	464.10
1984	5.70	1.30	7.00	37,800	491.40
1985	5.70	1.35	7.05	39,600	534.60

1986..... 5.70 1.45 7.15
42,000 609.00
1987..... 5.70 1.45 7.15
43,800 635.10
1988..... 6.06 1.45 7.51
45,000 652.50
1989..... 6.06 1.45 7.51
48,000 696.00
1990..... 6.20 1.45 7.65
51,300 743.85
1991..... 6.20 1.45 7.65
\1\125,00

0 1,812.50
1992..... 6.20 1.45 7.65
130,200 1,887.90
1993..... 6.20 1.45 7.65
135,000 1,957.50
1994..... 6.20 1.45 7.65
\2\none no limit
1995..... 6.20 1.45 7.65
none no limit
1996..... 6.20 1.45 7.65
none no limit

\1\The Omnibus Budget Reconciliation Act of 1990 created a separate taxable earnings base for HI. Prior to 1991, the OASDI and HI bases were the same.

\2\The Omnibus Budget Reconciliation Act of 1993 eliminated the taxable earnings base for HI for 1994 and later.

As table 5-19 demonstrates, the bulk of the financing for HI is derived from payroll taxes. In 1993, $400 million was transferred from the railroad retirement fund. This is the estimated amount that would have been in the fund if railroad

employment had always been covered under the Social Security Act.

HI benefits are provided to certain uninsured persons who became 72 before 1968. Such payments are made initially from the HI Trust Fund, with reimbursement from the general fund of the Treasury for the costs, including administrative expenses, of the payments. $367 million in 1993 and $506 million in 1994 was transferred to HI on this basis.

Certain persons not eligible for HI protection either on an insured basis or on the uninsured basis described in the previous paragraph may obtain protection by enrolling in the program and paying a monthly premium ($225 or $184 in 1994) as explained on Table 5-4. This accounts for an estimated $779 million of financing in fiscal year 1994.

Sections 217(g) and 229(b) of the Social Security Act, prior to modification by the Social Security Amendments of 1983, authorized annual reimbursement from the general fund of the Treasury to the HI Trust Fund for costs arising from the granting of deemed wage credits for military service prior to 1957, according to quinquennial determinations made by the Secretary of Health and Human Services. These sections, as modified by the Social Security Amendments of 1983, provided for a lump sum transfer in 1983 for costs arising from such wage credits. In addition, the lump sum transfer included combined employer-employee HI taxes on the noncontributory wage credits for military service after 1965 and before 1984. After

1983, HI taxes on military wage credits are credited to the fund on July 1 of each year. The Social Security Amendments of 1983 also provided for (1) quinquennial adjustments to the lump sum amount transferred in 1983 for costs arising from pre-1957 deemed wage credits and (2) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on noncontributory wage credits. In 1993, this accounts for $81 million of income to the HI trust fund.

The remaining $10,679 million in 1993 of receipts consisted almost entirely of interest on the investments of the trust fund.

TABLE 5-19.--INCOME TO THE HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS FOR SELECTED FISCAL YEARS, 1970-99

[In millions of dollars]

Fiscal year\1\	1970	1975	1980	1985	1990	1991	1992	1993	1994\2\	1995\2\	1999\2\	Percent of total financing
1995												

Hospital insurance:
Payroll taxes..... 4,785 11,291 23,244 46,490 70,655 74,655 80,978 83,147 92,106 101,472 127,184 57.7
Transfers from railroad retirement account..... 64 132 244 371 367 352 374 400 401 406 396 0.2
Reimbursement for uninsured persons..... 617 481 697 766 413 605 621 367 506 462 174 0.3
Premiums from voluntary enrollment\3\..... 0 6 17 38 113 367 484 622 779 864 1,271 0.5
Payments for military wage credits..... 11 48 141 86 107 \4\-1,011 86 81 80 68 64 0.0
Transfer from SMI Trust Fund \5\..... .... 1,805 0 0 0 0.0
Tax on Social Security Benefits..... .... 1,638 4,193 5,285 2.4
Interest on investment and other income..... 137 609 1,072 3,182 7,908 8,969 10,133 10,679 10,718 10,762 8,403 6.1

Total\6\..... 5,614 12,568 25,415 50,933 79,563 83,938 92,677 97,101 106,228 118,227 142,777 67.2

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Supplementary medical
 insurance:
    Premiums\7\...............   936   1,887   2,928
5,524   \8\11,494   11,807   12,748   14,683
16,802   19,192   24,101   10.0
    General revenues..........   928   2,330   6,932
17,898   33,210   34,730   38,684   44,227
38,148   36,955   78,173   21.0
    Transfer to HI
     Trustfund
\5\............. ....
....   -1,805   0   0
0   0
Interest and other income.....   12   105   415
1,155   \8\1,434   1,629   1,717   1,889
1,966   1,539   815   0.9

      Total\6\................   1,876   4,322   10,275
24,577   \8\46,138   48,166   53,149   58,994
57,686   57,686   103,689   32.8

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      Grand total.............   7,490   18,890   35,690
75,510   \8\125,701   132,104   145,826   156,095
163,144   175,913   245,866   100.0

\1\Fiscal years 1970 and 1975, consist of the 12 months ending on June 30 of each year.   \2\Administration projections under current law using fiscal
  year 1995 budget assumptions.   \3\Medicaid payment of

Medicare premiums is required on behalf of certain underpoverty persons on Medicaid, and over 65 years of age but not eligible for Medicare, effective January 1, 1989 according to the Medicare Catastrophic Coverage Act of 1988. \4\Includes the lump sum general revenue adjustment of $1,100 million as provided for by section 151 of Public Law 98-21. \5\Part B premiums paid into SMI Trust Fund for Medicare Catastrophic benefits; P.L. 102-394 required these funds to be transferred to the HI Trust Fund. \6\Totals do not necessarily equal sums of rounded components. \7\Includes SMI catastrophic premiums and supplemental catastrophic premium refund in fiscal year 1990. \8\Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

Source: 1994 Annual Reports of the Board of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds for 1970-94; current law using fiscal year 1995 budget assumptions for 1994-99.

Part B, which is voluntary, is financed from premiums paid by the aged, disabled and chronic renal disease enrollees and from the general revenues. The premium rate is derived annually based upon the projected costs of the program for the coming year. Under prior law, the premium rate was changed on July 1 of each year. The Social Security Amendments of 1983 (Public Law 98-21) moved the premium increase date to January 1 of each year to coincide with the changed date for the annual Social Security cash benefit cost-of-living (COLA) increase.

Ordinarily, the premium rate is the lower of: (1) an

amount
sufficient to cover one-half of the costs of the program for
the aged or (2) the current premium amount increased by the
percentage by which cash benefits were increased under the COLA
provisions of the Social Security program. Premium income,
which originally financed half of the costs of part B,
declined--as a result of this formula--to less than 25 percent
of total program income.

The Tax Equity and Fiscal Responsibility Act of 1982
(Public Law 97-248), temporarily suspended the COLA limitation
for 2 years--calendar years 1984 and 1985. During this period,
enrollee premiums were allowed to increase to amounts necessary
to produce premium income equal to 25 percent of program costs
for elderly enrollees. The Deficit Reduction Act of 1984
(Public Law 98-369) extended the TEFRA provision through
calendar years 1986 and 1987. The 1987 reconciliation bill
(Public Law 100-203) extended the provision through 1989 and
the 1989 reconciliation bill extended the provision through
1990. The Omnibus Reconciliation Act of 1990 set the premium
rates in law for each of the years 1991-95. The revenue
generated by these premium amounts were estimated to be
sufficient to pay approximately 25 percent of program costs for
these years. The flat premium for 1994 is $41.10 per month.
OBRA 1993 again set the premium equal to 25 percent of program
costs, without specifying the dollar amount, for 1996-98.

FINANCIAL STATUS OF THE TRUST FUNDS

The Hospital Insurance Trust Fund balances are dependent

upon the income to the HI Trust Fund primarily through payroll taxes exceeding the outlays for Medicare benefits and administrative costs. Outlays are affected by increases in inpatient hospital expenditures which have been rising at a faster rate than the income to the HI Trust Fund. Table 5-20 shows the annual percentage increase in Medicare outlays from fiscal year 1967 to fiscal year 1993 and the Congressional Budget Office (CBO) and HCFA projections from 1994 to 1999.

TABLE 5-20.--MEDICARE OUTLAYS, FISCAL YEARS 1967-99

Part A\1\		Part B		Total	
Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)
1967					
2,597	.....	799	.....	3,396	.....
1968					
3,815	46.9	1,532	91.7	5,347	57.4
1969					
4,758	24.7	1,840	20.1	6,598	23.4
1970					

4,953	4.1	2,196	19.3	7,149	8.4
1971					
5,592	12.9	2,283	4.0	7,875	10.2
1972					
6,276	12.2	2,544	11.4	8,820	12.0
1973					
6,842	9.0	2,637	3.7	9,479	7.5
1974					
8,065	17.9	3,283	24.5	11,348	19.7
1975					
10,612	31.6	4,170	27.0	14,782	30.3
1976\1\					
12,579	18.5	5,200	24.7	17,779	20.3
1977					
15,207	20.9	6,342	22.0	21,549	21.2
1978					
17,862	17.5	7,356	16.0	25,218	17.0
1979					
20,343	13.9	8,814	19.8	29,157	15.6
1980					
24,288	19.4	10,737	21.8	35,025	20.1
1981					
29,260	20.5	13,228	23.2	42,488	21.3
1982					
34,864	19.2	15,560	17.6	50,424	18.7
1983					
38,624	10.8	18,311	17.7	56,935	12.9
1984					
42,108	9.0	20,372	11.3	62,480	9.7
1985					
48,654	15.5	22,730	11.6	71,384	14.3
1986					
49,685	2.1	26,218	15.3	75,903	6.3
1987					
50,803	2.3	30,837	17.6	81,640	7.6
1988					
52,730	3.8	34,947	13.3	87,677	7.4
1989\2\					
58,238	10.4	38,317	9.6	96,555	10.1
1990\2\					
66,687	14.5	43,022	12.3	109,709	13.6

1991					
69,642	4.4	47,024	9.3	116,666	6.3
1992					
81,971	17.7	50,285	6.9	132,256	13.4
1993					
91,604	11.8	54,254	7.9	145,858	10.3
CBO projections\3\					
1994					
101,901	11.2	60,879	12.2	162,780	11.6
1995					
111,474	9.4	65,699	12.8	180,173	10.7
1996					
120,382	8.0	77,522	12.8	197,904	9.8
1997					
131,007	8.8	87,534	12.9	218,541	10.4
1998					
142,810	9.0	98,205	12.2	241,015	10.3
1999					
166,971	.....	.....	.....	.....	.....
HCFA projections\3\					
1994					
102,892	12.3	58,490	7.8	161,382	10.6
1995					
112,258	9.1	66,144	13.1	178,402	10.5
1996					
123,359	9.9	73,665	11.4	197,024	10.4
1997					
135,197	9.6	81,825	11.1	217,022	10.2
1998					
147,664	9.2	90,981	11.2	238,645	10.0
1999					
161,540	9.4	101,552	11.6	263,092	10.2

\1\In the transition quarter from July to October 1976 (when the beginning of the Federal fiscal year was changed), outlays were $4,805 million. These outlays do

not appear in the table.
\2\Includes Catastrophic outlays beginning in fiscal year 1989. There are no catastrophic outlays after fiscal year 1990.
\3\Projections under current law.

Source: 1993 Annual Report of the Board of Trustees: HI Trust Fund and SMI Trust Fund, HCFA Office of the Actuary. For 1991 through 1999, HCFA Division of Budget and CBO.

Supplementary medical insurance

Because the Supplementary Medical Insurance (SMI) Trust Fund is financed through beneficiary premiums and the general revenues, it does not face the prospect of depletion as does the HI Trust Fund. However, the rapidly rising cost of health care is placing a heavy burden on the SMI Trust Fund--causing beneficiary premiums to rise and increasing the Federal deficit.

HI trust fund income, outlays, and balance

Table 5-21 shows the projections of the Congressional Budget Office and the administration for the HI Trust Funds with respect to income, outlays and balances for the years 1993 through 1999.

TABLE 5-21.--PROJECTIONS FOR THE HOSPITAL INSURANCE TRUST FUND, FISCAL YEARS 1993-99 TOTAL OUTLAYS, INCOME, AND END-OF-YEAR BALANCES, UNDER CBO AND ADMINISTRATION BASELINE ASSUMPTIONS, PRESENT LAW

[By fiscal year, in billions of dollars]

	1993\1\	1994	1995	1996	1997	1998	1999
Total outlays	91.2	102.0	111.8	120.8	131.4	143.1	156.8
Income	92.1	101.6	118.5	125.9	131.7	138.1	143.8
Net additions	5.5	4.5	6.5	5.1	.3	5.0	(13.1)
End-of-year balance	127.4	130.7	137.5	142.8	142.8	137.8	124.7
Beginning-of-year balance, as percent of outlays	132	124	117	114	108	100	88

\1\Actuals.

Note: Components may not add to totals due to rounding.

Source: Congressional Budget Office, and HCFA Division of Budget.

Sensitivity of HI Trust Funds balances to different outlay growth assumptions

Table 5-22 presents alternative projections of Hospital Insurance (HI) Trust Fund outlay growth through 2009. All of these projections assume the economic projections underlying the baseline path. The alternatives all are arranged in the table from least to most growth. Hospital outlays are projected to grow by 1 or 2 percent less and 1 or 2 percent more than the baseline in each year. These changes could be due to variations in hospital rate increases, admission patterns, intensity

or
change in case mix, or technology changes. The percentage refers to entire hospital outlays and not just those outlays
covered by the prospective payment system.

Income to the trust fund is the same (except for interest
which varies by size of trust fund balance) in each projection.
Under the least growth alternative, expenditures are $143 billion in fiscal year 1998 compared to $149 billion in the baseline projection. Trust fund balances are $34 billion greater in this alternative.

TABLE 5-22.--ALTERNATIVE PROJECTIONS OF HOSPITAL INSURANCE OUTLAY GROWTH AND YEAR-END BALANCES

[By fiscal year, in billions of dollars]

	1993\1\	1994	1995	1996	1997	1998	1999	2000
2 percent lower HI outlay growth:								
Outlays	$91.5	$100.1	$107.8	$114.3	$122.1	$130.4	$140.5	$150
End-of-year balance\2\	125.1	132.5	143.6	155.8	155.7	175.5	183.1	188
1 percent lower HI outlay growth:								
Outlays	91.6	101.1	109.7	117.5	126.7	138.6	148.5	150
End-of-year balance\2\	126.1	131.5	140.5	149.2	154.9	157.4	154.4	147
Baseline:								
Outlays	91.5	102.0	111.8	120.8	131.4	143.1	156.9	170

```
    Income.............       87.1      106.5      115.6
125.8      131.7     138.1      143.8        150
    Yearly surplus......       5.5        4.6        6.8
5.1        0.3      (5.0)     (13.1)       (21)
    End-of-year
     balance\2\.........      126.1      130.7      137.5
142.5      142.8     137.8      124.7        104
1 percent higher HI
 outlay growth:
    Outlays.............       81.5      102.9      113.8
124.1      136.3     149.7      185.7        181
    End-of-year
     balance\2\.........                            134.3
135.7      130.3     117.7       94.1         50
2 percent higher HI
 outlay growth:
    Outlays.............       91.5      103.8      115.8
127.5      141.3     156.6      174.9        193
    End-of-year
     balance\2\.........      125.1      128.8      131.2
128.9      118.0      97.2       62.6         14
-------------------------------------------------------------
-------------------------------------------------------
                                          2001       2002
2003       2004       2005       2006       2007
-------------------------------------------------------------
-------------------------------------------------------
2 percent HI outlay growth:
    Outlays.....................       159        170
181        193        206        220        235
    End-of-year balance\2\.....       191        191
187        179        165        145        118
1 percent HI outlay growth:
    Outlays.....................       171        184
198        214        230        248        268
    End-of-year balance\2\.....       134        115
88         52          4        (56)      (129)
Baseline:
    Outlays.....................       184        200
218        235        267        280        305
    Income......................       155        160
```

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165        170        174        177        181
    Yearly surplus.................       (29)       (40)
(52)       (87)       (83)      (102)      (123)
    End-of-year balance\2\.........        75         35
(18)       (84)      (170)      (275)      (403)
1 percent higher HI outlay growth:
    Outlays........................       198        217
238        251        287        315        345
    End-of-year balance\2\.........        13        (49)
(128)      (228)      (352)      (504)      (688)
2 percent higher HI outlay growth:
    Outlays........................       213        235
251        289        320        354        393
    End-of-year balance\2\.........       (52)      (137)
(245)      (380)      (549)      (755)    (1,004)
-------------------------------------------------------------
-------------------------------------------------------
                                2008       2009       2010
2011       2012       2013       2014       2015
-------------------------------------------------------------
-------------------------------------------------------
2 percent lower HI
 outlay growth:
    Outlays.............       252        270        289
311        336        363        393        424
    End-of-year
     balance\2\.........        83         37        (20)
(91)      (179)      (287)      (416)      (575)
1 percent lower HI
 outlay growth:
    Outlays.............       289        313        339
358        401        437        477        520
    End-of-year
     balance\2\.........      (218)      (324)      (451)
(602)      (782)      (995)    (1,248)    (1,544)
Baseline:
    Outlays.............       332        363        397
434        478        526        579        637
    Income..............       185        188        191
195        198        201        204        208
    Yearly surplus......      (148)      (175)      (205)
```

(240) (280) (325) (375) (431)
End-of-year balance\2\..... (557) (744) (965)
(1,228) (1,542) (1,912) (2,347) (2,855)
1 percent higher HI outlay growth:
Outlays..... 381 420 463
512 568 631
End-of-year balance\2\..... (910) (1,175) (1,490)
(1,863) (2,305) (2,826) (3,439) (4,155)
2 percent higher HI outlay growth:
Outlays..... 437 486 540
602 675 758 847 950
End-of-year balance\2\..... (1,304) (1,662) (2,089)
(2,595) (3,186) (3,905) (4,740) (5,719)

\1\Actuals.
\2\Projections for fiscal years 1994 through 1999 assume economic and technical assumptions used in CBO baseline. Projections for fiscal years 1999-2015 are made by using the average of the growth rates for outlays and revenues in the last 2 years of CBO's baseline estimate. Outlay growth rates were further adjusted for changes in projected part A enrollment.

Note: Totals may not add due to rounding.

Source: Congressional Budget Office.

TABLE 5-23.--ACTUARIAL BALANCES OF THE HOSPITAL INSURANCE PROGRAM,
UNDER ALTERNATIVE SETS OF ASSUMPTIONS
[In percent]

Alternative			
	I	II	III
Projection periods			
1993-2017:			
Summarized tax rate\1\	2.90	2.90	2.90
Summarized cost rate\2\	3.99	5.01	6.36
Actuarial balance\3\	-1.09	-2.11	-3.46
1993-2042:			
Summarized tax rate\1\	2.90	2.90	2.90
Summarized cost rate\2\	4.52	6.84	10.81
Actuarial balance\3\	-1.62	-3.94	-7.91
1993-2067:			
Summarized tax rate\1\	2.90	2.90	2.90
Summarized cost rate\2\	4.94	8.01	13.51
Actuarial balance\3\	-2.04	-5.11	-10.61
25-year subperiods			
1993-2017:			
Summarized tax rate\1\	2.90	2.90	2.90
Summarized cost rate\4\	3.99	4.94	6.18
Actuarial balance\3\	-1.09	-2.04	-3.28
2018-2042:			
Summarized tax rate\1\	2.90	2.90	2.90

Summarized cost rate\4\	5.15	9.04	16.08
Actuarial balance\3\	-2.25	-6.14	-13.18
2043-2067:			
Summarized tax rate\1\	2.90	2.90	2.90
Summarized cost rate\4\	6.08	11.48	21.96
Actuarial balance\3\	-3.18	-8.58	-19.06

\1\As scheduled under present law.
\2\Expenditures for benefit payments and administrative costs for insured beneficiaries, on an incurred basis, expressed as a percentage of taxable payroll, computed on the present value, including the cost of attaining a trust fund balance at the end of the period equal to 100 percent of the following year's estimated expenditures, and including an offset to cost due to the beginning trust fund balance.
\3\Difference between the summarized tax rate (as scheduled under present law) and the summarized cost rate.
\4\Expenditures for benefit payments and administrative costs for insured beneficiaries, on an incurred basis, expressed as a percentage of taxable payroll, computed on the present-value basis. Includes neither the trust fund balance at the beginning of the period nor the cost of attaining a non-zero trust fund balance at the end of the period.

Source: Table 1.D.3 in the 1993 Annual Report of the Board of Trustees
of the Federal Hospital Insurance Trust Fund.

Long-range estimates

Long-range estimates for the next 75 years (1993-2067) are shown in table 5-23 for the HI program under all three alternative assumptions shown in the 1993 HI Trustees' report. As in the case of the OASDI program, annual expenditures are expressed as a percentage of taxable earnings. The income rate is simply the combined scheduled HI tax rate for employees and employers.

The average deficit over the next 25-year period is 2.11 percent of taxable earnings under alternative II assumptions. Over the next 75 years, is 5.11 percent of taxable earnings, that is, the cost rate is more than 175 percent higher than the tax rate now scheduled in the law for the future. In other words, the tax rate would have to be increased by 175 percent or program costs would have to be reduced by nearly 65 percent to restore actuarial solvency.

MEDICARE HISTORICAL DATA

Tables 5-24 through 5-38 present detailed historical data on the Medicare program. Tables 5-24 through 5-26 present detailed enrollment data. Table 5-27 describes the percentage of Medicare enrollees participating in a State buy-in

agreement. Tables 5-28 and 5-29 show the distribution of Medicare payments by type of coverage and type of service. Tables 5-30 and 5-31 show the number of persons served and average reimbursement amounts per person and per enrollee. Tables 5-32-36 present the use of inpatient hospital services,
skilled nursing facility services, home health agency services
and beneficiaries under the ESRD program. Table 5-37 presents
Medicare utilization and reimbursement by State and table 5-38
shows the number of Medicare enrollees in prepaid health plans.

TABLE 5-24.--NUMBER OF MEDICARE ENROLLEES, BY TYPE OF COVERAGE AND TYPE OF ENTITLEMENT, FOR SELECTED YEARS

Number of Medicare enrollees as of July 1 (in thousands)
Average annual percent

---

rate of growth

Type of entitlement and coverage	1968	1975	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1968-75	1975-84	1984-92

Total:
    HI\1\ and/or SMI\2\..... 19,821 24,959
28,478 29,010 29,494   30,026   30,456   31,083   31,750
32,411   32,980   33,579   34,203   34,870   35,579   3.3
1.9   2.0
    Total HI..... 19,770 24,640
28,067 28,590 29,069   29,587   29,996   30,589   31,216
31,853   32,413   33,040   33,719   34,429   35,153   3.2
1.9   2.0
    HI only..... 1,016   1,054
1,079   1,069   1,082   1,052   1,040   1,094   1,160
1,241   1,363   1,481   1,574   1,633   1,645   0.5
0.3   5.9
    Total SMI..... 18,805 23,905
27,400 27,941 28,412   8,975   29,416   29,989   30,590
31,170   31,617   32,099   32,629   33,237   33,933   3.5
1.9   1.8
    SMI only.....   51   318
411   420   425   439   460   493   534
558   567   539   484   441   425   29.9
3.3   -1.0
Aged:
    HI and/or SMI..... 19,821 22,790
25,515 26,011 26,540   27,109   27,571   28,176   28,791
29,380   29,879   30,409   30,948   31,485   32,010   2.0
1.7   1.9
    Total HI..... 19,770 22,472
25,104 25,591 26,115   26,670   27,112   27,683   28,257
28,822   29,312   29,869   30,464   31,043   31,584   1.8
1.7   1.9
    HI only.....   1,016   845
835   829   833   816   807   865   928
996   1,098   1,192   1,263   1,300   1,297   -2.6
-0.2   6.1
    Total SMI..... 18,805 21,945
24,680 25,182 25,707   26,292   26,765   27,311   27,863
28,382   28,780   29,216   29,686   30,185   30,712   2.2
1.8   1.7
    SMI only.....   51   318
411   420   425   439   459   493   534
558   557   539   484   441   425   29.9

3.3 -1.0
All disabled:
HI and/or SMI..... (\4\) 2,168
2,963 2,999 2,954 2,918 2,884 2,907 2,959
3,031 3,102 3,171 3,255 3,385 3,568 N/A
3/5 2.7
Total HI..... (\4\) 2,168
2,963 2,999 2,954 2,918 2,884 2,907 2,959
3,031 3,101 3,171 3,255 3,385 3,568 N/A
3.5 2.7
HI only..... (\4\) 209
244 239 249 235 233 229 232
243 265 288 311 333 348 N/A
2.0 5.1
Total SMI..... (\4\) 1,959
2,719 2,759 2,705 2,682 2,651 2,678 2,727
2,788 2,837 2,883 2,943 3,052 3,220 N/A
3.7 2.5
SMI only\3\.....
End stage renal disease only:
HI and/or SMI..... . (\4\) 13
28 27 27 28 30 31 39
47 53 58 65 69 72 N/A
8.5 11.6
Total HI..... (\4\) 13
28 27 27 28 30 31 39
47 53 58 65 69 69 N/A
8.5 11.6
HI only..... (\4\) 1
1 1 2 2 2 2 3
3 4 5 6 6 7 N/A
8.0 17.0
Total SMI..... (\4\) 12
27 26 26 26 28 29 36
44 49 54 59 62 65 N/A
9.0 11.1
SMI only \3\.....

\1\Hospital insurance. \2\Supplementary medical insurance. \3\Disabled and ESRD only must have HI to be eligible for SMI coverage. \4\Medicare disability entitlement began in 1973.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, ``Annual Program Statistics'' and unpublished data.

TABLE 5-25.--GROWTH IN NUMBER OF AGED MEDICARE ENROLLEES, BY SEX AND AGE, FOR SELECTED YEARS

Sex and age	Number of enrollees (in thousands)							Average annual percent growth rate			Enrollees as percent of total population
	Total aged population										
	1968\1\	1975\1\	1980	1981	1982	1984	1986	1987	1988	1989	1990	1991	1992	1968-75	1975-82	1982-92	1992\1\
1992																	
All persons.....	19,496	22,548	25,515	26,011	26,540	27,571	28,791	29,380	29,879	30,409	30,948	31,485	32,011	2.1	2.4		

1.9 32,285 99.2
65-69..... 6,551 7,642 8,459
8,570 8,652 8,784 9,163 9,358 9,469 9,659
9,695 9,690 9,692 2.2 1.8 1.1
9,977 97.1
70-74..... 5,458 5,950 6,756
6,888 7,022 7,300 7,564 7,647 7,752 7,775
7,951 8,163 8,373 1.2 2.4 1.8
8,483 98.7
75-79..... 3,935 4,313 4,809
4,931 5,064 5,327 5,573 5,692 5,792 5,931
6,058 6,175 6,261 1.3 2.3 2.1
6,415 97.6
80-84..... 2,249 2,793 3,081
3,112 3,185 3,382 3,559 3,659 3,764 3,856
3,957 4,085 4,166 3.1 1.9 2.7
4,150 100.4
85 and over..... 1,303 1,850 2,410
2,510 2,617 2,778 2,932 3,024 3,102 3,187
3,286 3,393 3,519 5.1 5.1 3.0
3,259 108.0
Males..... 8,177 9,201 10,268
10,454 10,653 11,044 11,525 11,762 11,967
12,187 12,416 12,650 12,886 1.7 2.1
1.9 13,045 98.8
65-69..... 2,944 3,420 3,788
3,843 3,881 3,942 4,109 4,196 4,245 4,331
4,352 4,358 4,374 2.2 1.8 1.2
4,475 97.7
70-74..... 2,322 2,504 2,841
2,898 2,958 3,088 3,214 3,255 3,308 3,323
3,406 3,505 3,604 1.1 2.4 2.0
3,651 98.7
75-79..... 1,596 1,669 1,854
1,903 1,956 2,061 2,160 2,211 2,257 2,321
2,382 2,441 2,485 0.6 2.3 2.4
2,553 97.3
80-84..... 864 1,005 1,062
1,068 1,093 1,161 1,221 1,257 1,296 1,330
1,369 1,411 1,454 2.2 1.2 2.9
1,457 99.8

85 and over.....	450	604	722	741	764	793	822	843	861	881	906	934	968
4.3	3.4	2.4	909	106.5									
Females.....	11,319	13,347	15,247	15,557	15,887	16,526	17,266	17,619	17,912	18,222	18,532	18,835	19,125
2.4	2.5	1.9	19,240	99.4									
65-69.....	3,606	4,222	4,671	4,727	4,771	4,842	5,054	5,162	5,224	5,328	5,343	5,332	5,317
2.3	1.8	1.1	5,503	96.6									
70-74.....	3,136	3,446	3,914	3,990	4,064	4,212	4,350	4,393	4,444	4,452	4,545	4,657	4,769
1.4	2.4	1.6	4,833	98.7									
75-79.....	2,338	2,644	2,954	3,028	3,108	3,266	3,414	3,481	3,534	3,610	3,676	3,734	3,776
1.8	2.3	2.0	3,862	97.8									
80-84.....	1,386	1,788	2,019	2,043	2,092	2,222	2,339	2,402	2,468	2,526	2,588	2,653	2,713
3.7	2.3	2.6	2,693	100.7									
85 and over.....	853	1,248	1,689	1,769	1,853	1,985	2,110	2,181	2,241	2,306	2,380	2,459	2,551
5.6	5.8	3.2	2,349	108.6									

\1\Total aged population data reflect U.S. residents.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, unpublished data; and U.S. Department of Commerce, Bureau of the Census.

TABLE 5-26.--GROWTH IN NUMBER OF DISABLED MEDICARE ENROLLEES WITH HI COVERAGE, BY TYPE OF

ENTITLEMENT AND AGE, FOR SELECTED YEARS

Type of entitlement and age	Number of enrollees										Average annual percent growth rate		
	1975	1980	1981	1982	1984	1988	1989	1990	1991	1992	1975-82	1982-88	1982-92
All disabled persons................................	2,058,424	2,425,231	2,998,949	2,415,646	2,884,410	3,101,482	3,170,917	3,254,983	3,385,439	3,568,625	2.3	4.3	4.0
Under age 35...................................	238,070	193,392	383,503	195,918	388,240	471,129	478,422	483,262	494,285	512,495	-2.7	15.7	10.1
35 to 44..	251,142	258,374	385,139	268,948	422,207	572,408	609,974	654,953	711,364	762,759	1.0	13.4	11.0
45 to 54..	508,345	572,823	654,700	532,020	584,214	670,131	705,616	741,193	790,435	874,797	.7	3.9	5.1
55 to 64..	1,060,967	1,400,642	1,575,607	1,418,762	1,489,749	1,397,814	1,376,905	1,375,575	1,389,355	1,419,574			

4.2 -0.2 -0.0
All disabled workers.....
1,638,662 2,396,897 2,439,446 2,388,299 2,309,866
2,456,135 2,510,319 2,579,097 2,693,502 2,856,517
5.5 0.5 1.8
Under age 35.....
100,439 184,619 195,000 187,514 193,094
249,291 253,918 257,760 268,392 286,466
9.3 4.9 4.3
35 to 44.....
164,439 253,186 269,765 264,036 290,395
414,749 445,291 482,071 530,417 576,549
7.0 7.8 8.1
45 to 54.....
426,451 565,846 558,519 525,384 485,378
552,442 581,969 612,692 657,358 731,713
3.0 0.8 3.4
55 to 64.....
947,333 1,393,246 1,416,162 1,411,365 1,340,999
1,239,653 1,229,141 1,226,574 1,237,335 1,216,769
5.9 -2.1 -1.1
Adults disabled as children.....
324,864 409,072 427,513 439,293 459,620
519,009 531,445 542,416 553,388 566,336
4.4 2.8 2.6
Under age 35.....
153,708 173,689 180,167 181,752 186,003
207,331 209,017 208,901 208,536 208,710
2.4 2.2 1.4
35 to 44.....
84,508 105,092 110,617 117,056 126,252
146,460 152,197 158,725 165,569 170,363
4.8 3.8 3.8
45 to 54.....
71,484 80,381 83,135 84,332 87,380
99,444 103,777 107,092 110,279 117,333
2.4 2.8 3.4
55 to 64.....
45,164 49,910 53,594 56,153 59,985
65,774 66,454 67,698 69,004 69,930
3.2 2.7 2.2

Widows and widowers.....
83,771 110,785 105,091 99,269 85,227
73,101 70,688 68,793 69,753 74,157
2.5 -5.0 -2.9
Under age 35.....
1 0 .....
0 ....
....
35 to
44..... .....
1 1
1 ....
.... -100.0
45 to 54.....
7,445 7,576 6,523 5,806 4,608
5,685 5,658 5,615 6,112 7,399
-3.5 -.4 2.5
55 to 64.....
76,325 103,208 98,567 93,462 80,618
67,416 65,030 63,178 63,641 66,758
2.9 -5.3 -3.3
End-stage renal disease only.....
11,127 28,334 26,899 27,347 29,697
53,237 58,465 64,677 68,796 71,615
13.7 11.7 10.1
Under age 35.....
3,729 8,773 8,336 8,404 9,143
14,507 10,368 16,601 17,357 17,299
12.3 9.5 7.5
35 to 44.....
2,187 5,188 4,756 4,912 5,559
11,199 12,486 14,157 15,378 15,847
12.3 14.7 12.4
45 to 54.....
2,966 6,977 6,523 6,636 6,848
12,560 14,212 15,794 16,686 18,352
12.2 11.2 10.7
55 to 64.....
2,245 7,396 7,284 7,397 8,147
14,971 16,280 18,125 19,375 20,117
18.6 12.5 10.5

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, unpublished data.

TABLE 5-27.--MEDICARE ENROLLMENT: NUMBER AND PERCENTAGE OF INDIVIDUALS ENROLLED IN SUPPLEMENTARY MEDICAL INSURANCE (SMI) UNDER BUY-IN AGREEMENTS, BY TYPE OF BENEFICIARY AND BY YEAR OR 1992 AREA OF RESIDENCE

Year or area of residence\1\	All persons		Aged		Disabled	
	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled	Number in thousands	Percent of SMI enrolled
Year:						
1968	1,648	8.8	1,648	8.8	NA	NA
1975	2,846	12.0	2,483	11.4	363	18.7
1980	2,954	10.9	2,449	10.0	504	18.9
1981	3,257	11.7	2,659	10.6	598	21.7
1982	2,791	9.8	2,288	8.9	503	18.6
1983	2,654	9.3	2,177	8.4	477	18.1

1984					2,601
8.9	2,127	8.0	474	18.2	
1985					2,670
9.0	2,164	8.0	505	19.2	
1986					2,776
9.2	2,222	8.0	554	20.9	
1987					2,985
9.6	2,337	8.2	648	23.2	
1988					3,033
9.6	2,341	8.1	691	24.4	
1989					3,351
10.4	2,549	8.7	802	27.8	
1990					3,604
11.0	2,714	9.1	890	30.2	
1991					3,766
10.4	2,817	8.7	949	27.8	
1992					4,055
11.4	2,972	9.3	1,083	30.3	

Area of residence\1\

All areas					4,055
11.4	2,972	9.3	1,083	30.3	
United States					4,053
11.6	2,970	9.5	1,083	31.3	
Alabama					108
17.8	84	16.0	24	29.3	
Alaska					6
21.4	4	16.7	2	50.0	
Arizona					35
6.5	25	5.1	10	20.0	
Arkansas					73
18.1	57	16.2	16	30.2	
California					697
20.4	527	17.0	170	53.0	
Colorado					41
10.7	29	8.5	12	30.0	
Connecticut					30
6.2	18	4.0	12	32.4	

Delaware	5	5.4	3	3.6	2	22.2
District of Columbia	13	16.7	10	14.1	3	42.9
Florida	222	9.0	175	7.7	47	25.8
Georgia	142	18.4	109	16.4	33	31.1
Hawaii	14	10.3	11	8.7	3	33.3
Idaho	10	7.2	7	5.5	3	25.0
Illinois	111	7.0	75	5.2	36	25.2
Indiana	68	8.6	47	6.7	21	25.3
Iowa	45	9.7	31	7.2	14	37.8
Kansas	32	8.6	23	6.7	9	31.0
Kentucky	84	15.2	60	12.8	24	28.9
Louisiana	98	17.8	74	15.6	24	30.8
Maine	25	13.2	17	10.1	8	38.1
Maryland	54	9.5	40	7.7	14	28.6
Massachusetts	98	10.9	68	8.4	30	36.1
Michigan	102	8.0	64	5.6	38	27.0
Minnesota	46	7.6	30	5.4	16	32.7
Mississippi	95	25.1	75	23.5	20	34.5
Missouri	62					

7.7 42 5.8 20 24.4

Montana..... 10
8.1 6 5.5 4 30.8

Nebraska..... 14
5.8 8 3.6 6 33.3

Nevada..... 11
6.8 8 5.5 3 20.0

New Hampshire..... 5
3.4 3 2.3 2 15.4

New Jersey..... 105
9.3 78 7.5 27 29.3

New Mexico..... 26
13.5 20 11.8 6 27.3

New York..... 275
10.8 197 8.5 78 31.7

North Carolina..... 139
14.7 107 12.9 32 27.4

North Dakota..... 5
5.0 3 3.2 2 25.0

Ohio..... 131
8.2 96 6.7 35 21.1

Oklahoma..... 55
11.8 43 10.8 12 27.3

Oregon..... 34
7.6 24 5.9 10 26.3

Pennsylvania..... 140
7.0 93 5.0 47 28.5

Rhode Island..... 12
7.4 8 5.4 4 26.7

South Carolina..... 89
19.0 67 16.6 22 34.4

South Dakota..... 10
8.8 7 6.7 3 33.3

Tennessee..... 127
17.6 93 14.8 34 36.2

Texas..... 265
13.8 212 12.2 53 29.3

Utah..... 12

7.0	7	4.5	5	33.3	
Vermont					9
11.7	6	8.6	3	37.5	
Virginia					89
11.7	66	9.8	23	27.4	
Washington					61
9.5	41	7.0	20	33.9	
West Virginia					33
10.4	23	8.5	10	21.3	
Wisconsin					71
9.7	44	6.6	27	39.7	
Wyoming					4
7.3	3	6.0	1	20.0	
Puerto Rico\2\					0
0.0	0	0.0	0	0.0	
Guam and Virgin Islands\3\					1
11.8	1	12.5	0	6.3	

\1\State of residence is not necessarily State that bought coverage.
\2\No State buy-in agreement.
\3\Data for these areas combined to prevent disclosure of confidential information.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, ``HCFA Statistics'' and unpublished data.

TABLE 5-28.--DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS, BY TYPE OF COVERAGE AND TYPE OF SERVICE, AND BY YEAR OR TYPE OF ENROLLEE

Amount and distribution of payments for all enrollees, calendar year--

Type of coverage and type of service	1975		1980		1981		1982		1983		1984		1985	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total payments (millions).....	15,588	100.0	35,686	100.0	43,442	100.0	51,086	100.0	57,443	100.0	62,870	100.0	70,391	100.0
Hospital insurance.....	11,315	72.6	25,051	70.2	30,329	69.8	35,631	69.7	39,337	68.5	43,209	68.7	47,444	67.4
Inpatient.....	10,877	69.8	24,116	67.6	29,161	67.1	33,947	66.5	37,252	64.9	40,878	65.0	44,940	63.8
Skilled nursing facility.....	254	1.6	395	1.1	410	0.9	484	0.9	543	0.9	543	0.9	548	0.8
Home health agency....	104	0.7	540	1.5	758	1.7	1,200	2.3	1,542	2.7	1,779	2.8	1,913	2.7

Hospice..............	0	0	0	0	0	0	0	0	0	0	8	0.0	43	0.1
Supplementary medical insurance................	4,273	27.4	10,635	29.8	13,113	30.2	15,455	30.3	18,106	31.5	19,661	31.3	22,947	32.6
Physicians'...........	3,416	21.9	8,187	22.9	10,086	23.2	11,893	23.3	14,062	24.5	15,434	24.5	17,312	24.6
Outpatient hospital...	643	4.1	1,897	5.3	2,406	5.5	2,994	5.9	3,385	5.9	3,452	5.5	4,319	6.1
Home health agency....	95	0.6	234	0.7	193	0.4	54	0.1	25	0.0	30	0.0	38	0.1
Group practice plan...	80	0.5	203	0.6	274	0.6	335	0.7	410	0.7	464	0.7	720	1.0
Independent laboratory	39	0.3	114	0.3	154	0.4	179	0.4	224	0.4	281	0.4	558	0.8

Amount and distribution of payments for all enrollees

Type of coverage and	1986	1987	1988	1989	1990

1991		1992							
type of service									
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total payments (millions).....	75,844	100.0	80,162	100.0	86,317	100.0	98,097	100.0	108,518	81.6
	118,653	100.0	132,951	100.0						
Hospital insurance.....	49,605	65.4	49,342	61.6	52,347	60.6	59,803	61.0	66,050	49.7
	71,317	60.1	83,691	62.9						
Inpatient.....	47,008	62.0	46,905	58.5	49,265	57.1	54,227	55.3	59,383	44.7
	62,640	52.8	71,000	53.4						
Skilled nursing facility.....	575	0.8	635	0.8	848	1.0	2,879	2.9	2,620	2.0
	2,632	2.2	4,051	3.0						
Home health agency.	1,945	2.6	1,690	2.1	2,078	2.4	2,465	2.5	3,689	2.8
	5,484	4.6	7,760	5.8						
Hospice.....	77	0.1	112	0.1	156	0.2	238	0.2	358	0.3
	561	0.5	880	0.7						
Supplementary medical insurance.....	26,239	34.6	30,820	38.4						

33,970 39.4 38,294 39.0 42,468 31.9
47,336 39.9 49,260 37.1

Physicians'..... 19,213 25.3 22,618 28.2
24,372 28.2 27,056 27.6 29,609 22.3
32,313 27.2 32,394 24.4
Outpatient hospital 5,157 6.8 5,916 7.4
6,549 7.6 7,676 7.8 8,482 6.4
9,783 8.2 10,990 8.3
Home health agency. 31 0.0 40 0.0
47 0.1 60 0.1 74 0.1 65
0.1 71 0.1
Group practice plan 1,113 1.5 1,361 1.7
2,019 2.3 2,308 2.4 2,827 2.1
3,531 3.0 3,933 3.0
Independent
laboratory..... 725 1.0 885 1.1
983 1.1 1,194 1.2 1,476 1.1 1,644
1.4 1,872 1.4

Source: Health Care Financing Administration, Bureau of Data Management and Strategy and Office of the Actuary, unpublished data.

TABLE 5-29.--DISTRIBUTION OF MEDICARE BENEFIT PAYMENTS, BY TYPE OF COVERAGE AND TYPE OF SERVICE, AND BY TYPE OF ENROLLEE, 1992

Calendar year 1992 payments by type of enrollee

	All enrollees				Aged		Disabled	
	Amount (in millions)	Percentage distribution	Amount (in millions)	Percentage distribution	Amount (in millions)	Percentage distribution	Amount (in millions)	Percentage distribution
Total payments (millions)	132,951	100.0	15,419	100.0	117,532	100.0		
Hospital insurance	83,691	62.9	9,366	60.7	74,325	63.2		
Inpatient	71,000	53.4	8,662	56.2	62,338	53.0		
Skilled nursing facility	4,051	3.0	144	0.9	3,907	3.3		
Home health agency	7,760	5.8	516	3.3	7,244	6.2		
Hospice	880	0.7	44	0.3	836	0.7		
Supplementary medical insurance	49,260	37.1	6,053	39.3	43,207	36.8		
Physicians'	32,394	24.4	3,225	20.9	29,169	24.8		
Outpatient hospital	10,990	8.3	2,250	14.6	8,740	7.4		
Home health agency	71	0.1	0	0.0	71	0.1		
Group practice plan	3,933	3.0	392	2.5	3,541	3.0		
Independent laboratory	1,872	1.4	186	1.2	1,686	1.4		

Source: Health Care Financing Administration, Bureau of

Data Management and Strategy and Office of the Actuary, unpublished data.

TABLE 5-30.--PERSONS SERVED AND REIMBURSEMENTS FOR AGED MEDICARE ENROLLEES, BY TYPE OF COVERAGE AND BY YEAR OR 1992 DEMOGRAPHIC CHARACTERISTICS

Year, period, or 1992 characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance and/or Supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served	Per 1,000 person enrollees	Reimbursements per enrollee served	Persons served	Per 1,000 person enrollees	Reimbursements per enrollee served	Persons served	Per 1,000 person enrollees	Reimbursements per enrollee served	Persons served	Per 1,000 person enrollees	Reimbursements per enrollee served
Year:												
1968	397.8	$670.08	$266.56	204.0	$934.42							

$190.67 394.8 $203.94 $80.51
1975.....
527.9 1,054.63 556.78 220.9 1,855.38
409.78 536.0 295.91 158.60
1980.....
637.7 1,790.51 1,141.84 240.0 3,378.53
810.77 652.3 545.42 355.77
1981.....
655.0 2,024.49 1,325.97 243.4 3,877.39
943.84 669.5 613.13 410.47
1982.....
641.4 2,439.38 1,564.65 250.7 4,461.53
1,118.69 653.8 732.53 478.92
1983.....
660.2 2,610.80 1,723.69 250.9 4,803.71
1,205.13 672.2 825.26 554.77
1984.....
685.7 NA NA 239.6 NA
NA 698.9 NA NA
1985.....
722.1 2,762.06 1,994.59 218.8 6,167.28
1,349.60 739.1 933.25 689.79
1986.....
731.7 2,870.05 2,099.93 213.0 6,528.36
1,390.28 750.8 1,012.17 759.95
1987.....
754.1 3,025.22 2,281.19 209.8 6,902.60
1,448.33 775.9 1,147.95 890.64
1988.....
767.8 3,177.60 2,439.87 207.5 7,514.76
1,559.23 792.5 1,192.41 944.96
1989.....
784.9 3,444.86 2,703.90 206.1 8,196.19
1,688.96 812.8 1,338.10 1,087.56
1990.....
801.6 3,578.43 2,868.57 209.0 8,519.97
1,780.60 831.6 1,398.86 1,163.29
1991.....
800.1 3,905.65 3,124.82 211.8 9,348.53
1,980.26 830.0 1,473.27 1,222.80
1992.....

794.4 4,193.90 3,331.60 213.0 10,126.3
2,157.2 823.4 1,522.9 1,254.0
Annual percentage change in period:
    1968 to 1975.....
4.1 6.7 11.1 1.1 10.3 11.5
4.5 5.5 10.2
    1975 to 1985.....
3.2 10.1 13.6 -0.1 12.8 12.7
3.3 12.2 15.8
    1985 to 1992.....
2.8 11.0 14.1 -1.9 14.7 12.5
3.0 13.9 17.3
Age:
    65 and 66 years.....
747.9 $2,850.26 $2,131.65 132.5 $9,778.39
$1,295.25 811.0 $1,147.25 $930.46
    67 and 68 years.....
709.7 3,414.87 2,423.50 143.0 10,319.07
1,475.46 753.1 1,367.88 1,030.12
    69 and 70 years.....
743.2 3,599.13 2,674.74 159.9 10,241.04
1,637.48 775.5 1,431.25 1,109.94
    71 and 72 years.....
758.9 3,910.35 2,967.44 176.0 10,507.15
1,848.89 780.7 1,513.47 1,181.60
    73 and 74 years.....
799.5 4,144.01 3,312.95 198.0 10,485.84
2,076.62 813.9 1,587.84 1,292.42
    75 to 79 years.....
831.0 4,635.29 3,851.76 235.6 10,550.66
2,485.48 842.7 1,694.16 1,427.75
    80 to 84 years.....
860.3 4,966.50 4,272.89 288.9 9,969.93
2,880.67 871.6 1,683.09 1,467.05
    85 years and over.....
882.4 5,337.27 4,709.47 357.0 9,424.71
3,364.45 921.2 1,582.57 1,457.79
Sex:
    Male.....
754.3 4,677.45 3,527.97 215.6 10,669.68
2,300.06 790.1 1,669.79 1,319.38

Female					
821.5	3,894.72	3,199.36	211.3	9,750.52	
2,060.40	845.3	1,432.36	1,210.78		
Race:					
White					
803.0	4,124.04	3,311.48	213.7	9,965.58	
2,129.90	829.5	1,500.23	1,244.39		
All other					
732.5	4,877.32	3,572.67	211.8	11,457.45	
2,426.51	775.7	1,747.96	1,355.95		
Census region:					
Northeast					
830.2	4,525.56	3,757.30	218.5	11,224.99	
2,452.61	859.2	1,622.32	1,393.85		
North Central					
824.9	3,873.28	3,195.13	218.7	9,503.69	
2,078.32	843.7	1,378.56	1,163.12		
South					
826.7	4,235.65	3,501.53	234.0	9,670.71	
2,262.99	846.6	1,533.64	1,298.44		
West					
697.8	4,251.20	2,966.66	170.4	11,177.96	
1,904.55	715.9	1,606.35	1,149.92		

Note.--Data for 1992 are considered preliminary.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, ``Annual Medicare Program Statistics.''

TABLE 5-31.--PERSONS SERVED AND REIMBURSEMENTS FOR DISABLED ENROLLEES, BY TYPE OF COVERAGE AND BY YEAR OR 1992 DEMOGRAPHIC CHARACTERISTICS

Hospital insurance and/or			Hospital insurance		

Supplementary medical insurance

supplementary medical insurance

Reimbursements Reimbursements

Reimbursements Persons ---
Persons ---
Year, period, or 1992 characteristic
Persons --- served
served

served Per per 1,000 Per person
Per per 1,000 Per Per
per
1,000 person Per enrollees served
enrollee enrollees person enrollee

enrollees served enrollee
served

Year:
1968.....
NA NA NA NA NA NA
NA NA NA
1975.....
449.5 $1,548.09 $695.83 219.2 $2,076.58
$455.20 471.4 $564.95 $266.32
1980.....
594.1 2,544.04 1,511.34 245.7 3,798.09
933.16 633.8 994.18 630.06
1981.....
615.2 2,880.99 1,772.39 251.4 4,400.27
1,106.16 655.9 1,103.92 724.04
1982.....
608.9 3,431.26 2,089.35 256.9 5,109.65

1,312.85 650.5 1,303.37 847.90
1983.....
628.8 3,658.08 2,300.24 257.7 5,549.82
1,430.30 670.1 1,412.07 946.23
1984.....
639.5 NA NA 242.6 NA
NA 683.5 NA NA
1985.....
668.8 3,855.22 2,578.24 227.9 7,223.96
1,646.25 715.5 1,414.04 1,011.70
1986.....
681.0 4,032.05 2,745.64 226.3 7,622.94
1,724.99 729.0 1,518.86 1,107.32
1987.....
695.7 3,993.70 2,778.14 219.4 7,610.01
1,669.66 747.8 1,611.42 1,205.10
1988.....
703.7 4,114.84 2,895.52 209.3 8,372.64
1,752.76 760.0 1,643.77 1,249.35
1989.....
721.3 4,530.89 3,268.36 208.0 9,481.76
1,971.89 785.0 1,816.65 1,426.08
1990.....
734.3 4,702.65 3,452.97 208.9 9,846.77
2,056.60 803.5 1,921.76 1,544.18
1991.....
728.5 5,069.61 3,693.15 208.7 10,634.43
2,218.91 799.0 2,046.50 1,635.16
1992.....
729.3 5,351.81 3,903.33 208.9 11,278.42
2,355.73 799.4 2,145.26 1,714.91
Annual percentage change in period:
1968 to 1975.....
NA NA NA NA NA NA
NA NA NA
1975 to 1985.....
4.05 9.55 13.99 0.39 13.28
13.72 4.26 9.61 14.28
1985 to 1992.....
1.24 4.80 6.10 -1.24 6.57
5.25 1.60 6.14 7.83

Age:
    Under 35 years.....
706.9 $5,425.42 $3,835.41   199.1 $11,566.96
$2,303.03   766.9 $2,190.43 $1,679.83
    35 to 44 years.....
688.7   5,099.80   3,512.47   185.7   11,181.41
2,075.86   760.1   2,108.41   1,602.53
    45 to 54 years.....
703.5   5,316.64   3,740.06   196.3   11,241.57
2,206.84   777.8   2,202.85   1,713.36
    55 to 59 years.....
732.0   5,560.89   4,070.48   216.5   11,392.43
2,466.48   803.8   2,215.65   1,780.94
    60 to 64 years.....
805.9   5,407.53   4,358.09   244.1   11,160.37
2,723.92   874.3   2,051.32   1,793.54
Sex:
    Male.....
682.6   5,304.28   3,620.77   196.6   11,423.79
2,245.59   751.4   2,040.09   1,532.94
    Female.....
805.1   5,417.11   4,361.16   228.8   11,076.07
2,534.18   875.9   2,289.19   2,005.20
Race:
    White.....
727.8   4,900.77   3,566.59   202.1   10,868.66
2,196.28   800.0   1,903.04   1,522.51
    All other.....
735.3   6,702.86   4,928.56   230.0   12,353.36
2,840.81   799.5   2,872.19   2,296.19
Census region:
    Northeast.....
755.8   5,775.08   4,364.60   210.4   12,699.79
2,672.11   831.5   2,267.46   1,885.46
    North Central.....
737.0   4,947.12   3,646.04   207.6   10,818.63
2,245.69   805.6   1,920.02   1,546.76
    South.....
756.4   5,286.27   3,998.42   229.9   10,547.60
2,424.58   805.8   2,100.26   1,692.44

West.....
694.1 5,842.26 4,055.22 182.3 12,933.15
2,357.77 751.9 2,468.12 1,855.80

NA--Not available.

Note.--Data for 1992 are considered preliminary.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, ``Annual Medicare Program Statistics.''

TABLE 5-32.--USE OF INPATIENT HOSPITAL SERVICES BY MEDICARE ENROLLEES, BY TYPE OF ENROLLEE AND TYPE OF HOSPITAL: CALENDAR YEAR 1991\1\

Type of enrollee and type of hospital	Number in thousands	Per 1,000 enrollees	Covered days of care Number in thousands	Per bill	Bills\2\ Reimbursements in dollars Amount in millions	Per enrollee
All enrollees:						
All hospitals.....	11,426	328	95,569	8.4	2,741	62,122	5,437	1,782
Short-stay.....	10,917	313	90,381	8.3	2,592	60,255	5,519	1,728
Long-stay.....	509	15	5,188	10.2	149	1,867	3,665	54

Psychiatric.....			287		8	
2,660	9.3	76	726	2,529		21
All other.....			222		6	
2,527	11.4	72	1,141	5,130		33
Aged:						
All hospitals.....			9,982		317	
83,786	8.4	2,661	54,981	5,508		1,746
Short-stay.....			9,679		307	
80,450	8.3	2,555	53,644	5,543		1,704
Long-stay.....			304		10	
3,337	11.0	106	1,337	4,401		42
Psychiatric.....			104		3	
1,041	10.0	33	310	2,981		10
All other.....			200		6	
2,295	11.5	73	1,027	5,140		33
Disabled:						
All hospitals.....			1,444		426	
11,783	8.2	3,480	7,140	4,945		2,109
Short-stay.....			1,238		366	
9,931	8.0	2,933	6,610	5,338		1,953
Long-stay.....			206		61	
1,852	9.0	547	530	2,578		157
Psychiatric.....			183		54	
1,619	8.8	478	416	2,272		123
All other.....			23		7	
232	10.2	68	114	5,047		34

\1\Preliminary data. Detail may not add due to rounding.
\2\Discharges not available by type of hospital.

Note.--Only services rendered by inpatient hospitals are included.

Source: Health Care Financing Administration, Bureau of Management and Strategy, unpublished data.

TABLE 5-33.--USE OF SHORT-STAY HOSPITAL SERVICES BY AGED MEDICARE ENROLLEES, BY FISCAL YEAR OR 1991 DEMOGRAPHIC CHARACTERISTICS

Calendar year, period, or characteristic	Total	Discharges	Total days of care		Total charges	Aged hospital insurance charges	Per enrollee (in 1991 dollars)
	Number (in thousands)	Per 1,000 enrollees	Number (in thousands)	Per discharge	Per enrollee (in millions)	Per 1,000 covered enrollees (in thousands)\1\	Per enrollee
							Per day of care
Year:							
1975	22,472	324	81,592	11.2	3,631	7,285	527
1980	25,104	361	96,772	10.7	3,855	9,051	1,120
1982	26,115	376	100,431	10.0	3,846	9,817	1,565
1984	27,112	358	86,062	8.9	3,174	9,705	1,732
1985	27,683	322	76,926	8.6	2,779	8,918	1,711
1986	28,257	316	77,240	8.7	2,733	8,917	1,862
	52,623	5,901	681			47,371	

1987..... 28,822
9,000 312 79,804 8.9 2,769
60,900 6,767 763 2,113
1988..... 29,312
9,146 312 80,938 8.8 2,761
69,920 7,645 864 2,385
1989..... 29,869
9,026 302 79,784 8.8 2,671
78,204 8,664 980 2,618
1990..... 30,948
9,351 302 82,179 8.8 2,655
102,544 10,966 1,248 3,313
1991..... 31,043
9,645 311 82,743 8.6 2,665
118,882 12,326 1,437 3,830
Annual percentage change in period:
1975-82..... 2.2
4.4 2.1 3.0 -1.6 0.8
19.3 14.4 15.9 16.8
1982-91..... 1.9
-0.2 -2.1 -2.1 -1.7 -4.0
12.6 12.8 15.0 10.5
Age:
65-69 years..... 9,571
NA NA NA NA NA NA
NA NA NA
70-74 years..... 8,050
NA NA NA NA NA NA
NA NA NA
75-79 years..... 6,078
NA NA NA NA NA NA
NA NA NA
80-84 years..... 3,990
NA NA NA NA NA NA
NA NA NA
85 years or over..... 3,354
NA NA NA NA NA NA
NA NA NA
Sex:
Male..... 12,523
NA NA NA NA NA NA

NA NA NA

Female..... 18,520

NA NA NA NA NA NA

NA NA NA

Race:\2\

White..... 26,948

NA NA NA NA NA NA

NA NA NA

All other..... 3,066

NA NA NA NA NA NA

NA NA NA

Census region:

Northeast..... 6,793

NA NA NA NA NA NA

NA NA NA

North central..... 7,688

NA NA NA NA NA NA

NA NA NA

South..... 10,388

NA NA NA NA NA NA

NA NA NA

West..... 5,555

NA NA NA NA NA NA

NA NA NA

\1\As of July 1.

\2\Excludes unknown race.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

TABLE 5-34.--USE OF SKILLED NURSING FACILITY SERVICES AND PERCENTAGE CHANGE, BY TYPE OF MEDICARE ENROLLEE, AND CALENDAR YEAR OR PERIOD, OR 1991

DEMOGRAPHIC CHARACTERISTIC

Type of enrollee and year, period, or characteristic	Persons served 1991 Number of facilities\1\	Persons served 1991 Number in thousands\2\\3\	Persons served 1991 Per 1,000 enrollees	Covered days of care Number in thousands	Covered days of care Per enrollee served	Covered days of care Per person served	Reimbursements HI aged enrollees Amounts in millions	Reimbursements HI aged enrollees Per enrollee served	Reimbursements HI aged enrollees Per day
Aged									
Year:									
1969\3\	4,786	20,014	394	19.7	17,520	45	0.9	$311	$790	$16	$18
1975	3,932	22,472	260	11.5	8,585	33	0.4	233	896	10	27
1981	5,295	25,591	243	9.5	8,373	34	0.3	361	1,486	14	43
1982	5,510	26,115	244	9.3	8,549	35	0.3	388	1,591	15	45
1983	5,760	26,670	257	9.6	9,007	35	0.3	413	1,612	16	46

1984.....			6,183			27,112								
290	10.7	9,309	32	0.3	458									
1,581	17	49												
1985.....			6,725			27,683								
304	11.0	8,615	28	0.3	464									
1,525	17	54												
1986.....			7,065			28,257								
294	10.4	7,867	27	0.3	474									
1,613	17	60												
1987.....			7,148			28,822								
283	9.8	7,139	25	0.2	524									
1,853	18	73												
1988.....			7,683			29,312								
371	12.7	10,681	29	0.4	811									
2,184	28	76												
1989.....			8,688			29,869								
613	20.5	28,522	47	1.0	2,806									
4,580	94	98												
1990.....			9,008			30,464								
615	20.2	22,873	37	0.8	1,886									
3,068	62	82												
1991.....			9,674			31,043								
648	20.9	21,415	33	0.7	2,151									
3,321	69	100												
Annual percentage change in period:														
1969 to 1975.....			-3.2			1.9								
-6.7	-8.5	-11.2	-4.8	-12.9	-4.7									
2.1	-6.6	7.3												
1975 to 1981.....			5.1			2.2								
-1.1	-3.2	-0.4	0.7	-2.5	7.6									
8.8	5.3	8.1												
1981 to 1986.....			5.9			2.0								
3.9	1.8	-1.2	-4.9	-3.2	5.6									
1.6	3.5	6.9												
1986 to 1991.....			6.5			1.9								
17.1	15.0	22.2	4.3	19.9	35.3									
15.5	32.8	10.8												
Age:														
65 to 69 years.....			.....			9,571								
51	5.3	NA	NA	NA	172									

3,367	18	NA				
70 to 74 years.....	.....					8,050
87	10.8	NA	NA	NA	298	
3,420	37	NA				
75 to 79 years.....	.....					6,078
129	21.2	NA	NA	NA	438	
3,407	72	NA				
80 to 84 years.....	.....					3,990
153	38.4	NA	NA	NA	508	
3,312	127	NA				
85 years or over....	.....					3,354
227	67.8	NA	NA	NA	734	
3,230	219	NA				
Sex:						
Male.....	.....					12,523
209	16.7	NA	NA	NA	682	
3,006	54	NA				
Female.....	.....					12,523
209	16.7	NA	NA	NA	147	
3,096	12	NA				
Race:\4\						
White.....	.....					26,948
582	21.6	NA	NA	NA	1,917	
3,025	71	NA				
All other.....	.....					3,067
48	15.8	NA	NA	NA	177	
3,536	58	NA				
Census region:						
Northeast.....		1,954			6,793	
116	17.0	4,839	42	0.7	373	
3,227	55	77				
North Central.....		2,569			7,688	
210	27.3	6,599	31	0.9	613	
2,918	80	93				
South.....		2,479			10,388	
178	17.2	5,940	33	0.6	566	
3,173	54	95				

Disabled

Year:

1975.....	3,932	2,168	8	3.9	289	34	0.1	9	1,049	4	30		
1980.....	5,155	2,963	9	2.9	319	38	0.1	13	1,571	5	42		
1982.....	5,510	2,954	8	2.6	296	38	0.1	14	1,762	5	46		
1983.....	5,760	2,918	8	2.7	305	38	0.1	15	1,856	5	48		
1984.....	6,183	2,884	9	3.1	314	35	0.1	15	1,675	5	47		
1985.....	6,725	2,907	10	3.5	305	30	0.1	17	1,681	6	57		
1986.....	7,065	2,959	10	3.5	295	29	0.1	19	1,872	6	65		
1987.....	7,148	3,031	10	3.3	272	27	0.1	21	2,154	7	79		
1988.....	7,683	3,101	13	4.2	401	31	0.1	33	2,529	11	81		
1989.....	8,688	3,171	23	7.4	1,437	61	0.5	143	6,107	45	100		
1990.....	9,008	3,255	23	7.1	1,022	44	0.3	85	3,696	26	83		

1991................	9,674	3,385	23	6.7	825	36	0.2	87	3,846	26	106
Annual percentage change in period:											
1975-80............	5.6	6.4	0.3	-5.8	2.0	1.7	-4.2	8.7	8.4	2.1	6.6
1980-85............	5.5	-0.4	3.9	4.3	-0.9	-4.6	-0.5	5.3	1.4	5.7	6.3
1985-91............	6.2	2.6	14.0	11.2	18.1	3.5	15.1	30.9	14.8	27.6	10.9
Age:											
Under 35 years......	....	494	1	2.7	NA	NA	NA	6	4,590	12	NA
35 to 44 years......	....	711	3	3.9	NA	NA	NA	12	4,467	17	NA
45 to 54 years......	....	790	5	6.0	NA	NA	NA	19	3,929	24	NA
55 to 59 years......	....	568	5	8.1	NA	NA	NA	18	3,853	31	NA
60 to 64 years......	....	821	9	11.2	NA	NA	NA	32	3,507	39	NA
Sex:											
Male................	....	2,111	12	5.9	NA	NA	NA	48	3,868	23	NA
Female.............	....	1,274	10	8.4	NA	NA	NA	39	3,818	30	NA
Race:\4\											
White..............	....	2,547	18	6.9	NA	NA	NA	65	3,711	26	NA

All other.....	.....						773		
5	6.0	NA	NA	NA	20				
4,361	26	NA							
Census region:									
Northeast.....			1,954				647		
3	5.4	149	48	0.2	11				
3,618	17	76							
North Central.....			2,569				797		
7	9.3	252	37	0.3	23				
3,400	29	93							
South.....			2,479				1,266		
7	5.6	239	36	0.2	24				
3,614	19	101							
West.....			1,997				565		
6	10.0	182	31	0.3	28				
4,764	50	154							

\1\Number serving either aged or disabled Medicare enrollees, as of January 1991.
\2\As of July 1.
\3\Regions exclude residence unknown and territories.
\4\Excludes unknown race.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, unpublished data.

TABLE 5-35.--VISITS, CHARGES, AND REIMBURSEMENTS FOR HOME HEALTH AGENCY SERVICES AND PERCENTAGE CHANGES BY CALENDAR YEAR OR PERIOD, OR DEMOGRAPHIC

CHARACTERISTICS	Visits	Charges\1\	Reimbursements

Amount Amount (in millions) Average

Calendar year, period, or 1992 Number

Total in Amount ------------------------------

annual Total Total

characteristic\2\ in Per

1,000 amount millions per

percentage per per

millions

enrollees in for visit HI SMI

Total change in visit enrollee

millions visits

total

Year:

1969...............................	9	424	$88	NA	NA	$52	$26	$78	....	$9	$4
1975...............................	11	431	226	211	20	152	63	215	18.4	20	9
1980...............................	23	792	775	739	33	490	176	666	25.4	30	23
1983...............................	38	1,253	1,689	1,627	43	1,405	22	1,427	28.9	38	48
1984...............................	41	1,358	2,026	1,912	46	1,677	27	1,704	19.4	41	56
1985...............................	40	1,303	2,152	1,979	49	1,766	31	1,797	5.4	44	58
1986...............................	39	1,229	2,214	2,125	54	1,781	36	1,817	1.1	47	57
1987...............................	37										

1,138 2,236 2,127 58 1,774 39
1,813 -0.2 49 56
1988..... 38
1,156 2,472 2,358 62 1,916 44
1,960 8.1 51 59
1989..... 47
1,404 3,233 3,106 66 2,368 57
2,426 23.8 51 72
1990..... 70
2,045 5,007 4,841 69 3,626 69
3,695 52.3 53 108
1991..... 99
2,852 7,348 5,342 71 5,281 61
5,342 44.6 54 153
1992..... 134
3,759 10,377 10,034 75 7,367 80
7,477 39.4 56 209

Annual percentage change in period:
1969 to 1975..... 4.0
0.3 17.1 NA NA 19.7 15.8
18.4 ..... 13.9 14.2
1975 to 1983..... 16.9
14.3 28.6 29.1 10.0 32.1 -12.4
26.7 ..... 8.4 23.8
1983 to 1992..... 15.1
13.0 22.3 22.4 6.4 20.2 15.5
20.2 3.5 4.4 17.9
Type of enrollee:
Aged..... 118
3,676 9,132 8,830 ..... 6,483 71
6,553 ..... 56 205
Disabled..... 16
4,497 1,245 1,204 ..... 884 9
894 ..... 56 251
Sex:
Male..... NA
NA NA NA NA NA NA
NA NA NA NA
Female..... NA
NA NA NA NA NA NA

NA NA NA NA
Race:\2\
White..... NA
NA NA NA NA NA NA
NA NA NA NA
All other..... NA
NA NA NA NA NA NA
NA NA NA NA

\1\Excludes durable medical equipment and supplies, except for drugs and biologicals, furnished by home health agencies.
\2\Data for 1992 as of September 1993.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, unpublished data.

TABLE 5-36.--SELECTED UTILIZATION AND REIMBURSEMENT DATA FOR END-STAGE RENAL DISEASE, AND KIDNEY TRANSPLANT PROGRAMS FOR SELECTED CALENDAR YEARS

Program and key program variables

1975 1983 1984 1985 1986 1987
1988 1989 1990 1991

End stage renal disease program:\1\ Beneficiaries:
Number.....
12,702 27,847 29,397 30,876 38,970 47,222
53,247 58,409 64,692 68,807
Percentage change
\2\..... ..... 1.8
5.6 5.0 26.2 21.2 12.8 9.8
10.6 6.4
Expenditures:

Total (in millions).....
$361 $1,898 $2,381 $2,680 $3,108 $3,441
$3,851 $4,528 $5,262 $6,154
Percentage change
\2\..... ..... 23.1
25.4 12.6 16.0 10.7 11.9 17.6
16.2 17.0
Expenditures per beneficiary:
Amount (in dollars)\3\.....
$16,185 $21,228 $22,245 $23,479 $24,957 $25,501
$25,852 $27,726 $29,480 $31,899
Percentage change
\2\..... ..... 3.4
4.8 5.5 6.3 2.2 1.4 8.4
6.3 8.2
New beneficiaries during year:
Number.....
6,763 6,738 7,532 9,372 14,696 15,570
17,416 19,340 19,913 20,140
Percentage change
\2\..... ..... 0.0
11.8 24.4 56.8 5.9 11.9 11.0
3.0 1.1
Kidney transplant program:\4\ Total transplants:
Number of patients\5\.....
3,730 6,112 6,968 7,695 8,976 8,967
8,932 8,899 9,796 10,026
Percentage change
\2\..... ..... 14.1
14.0 10.4 16.6 -0.1 -0.4 -0.4
10.1 2.4
Kidney transplanted from living donors:\6\
Number.....
NA 1,784 1,704 1,876 1,887 1,907
1,816 1,893 2,091 2,382
Percentage of total
transplants..... ..... 31.9 27.0
26.5 22.9 23.0 -4.8 4.2 21.3
13.9
Number of beneficiaries losing entitlement because
of 3-year limitation.....

NA NA NA NA NA NA
NA NA NA NA

\1\Persons entitled solely because of end stage renal disease.
\2\For intervals of more than one year, rate shown is average annual rate of change.
\3\Not adjusted for PPS pass-throughs.
\4\Transplants in Medicare-certified U.S. hospitals.
\5\Transplant count includes non-Medicare patients.
\6\Includes transplants to non-Medicare patients.

NA--Not available.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, and OACT.

TABLE 5-37.--MEDICARE UTILIZATION AND REIMBURSEMENT: NUMBER OF AGED PERSONS SERVED UNDER HOSPITAL INSURANCE AND/OR SUPPLEMENTARY MEDICAL INSURANCE PER 1,000 ENROLLED, AMOUNT REIMBURSED PER PERSON SERVED, AND PERCENTAGE CHANGE, BY CENSUS DIVISION AND STATE, FOR SELECTED CALENDAR YEARS

Persons served per 1,000 enrolled
Reimbursement per person served

Annual percent change
Annual percent change

	1967	1985	1990	1991	1992\3\	1967-92	1985-90	1990-91	1991-92	1967	1985	1990	1991	1992\3\	1967-91	1985-90	1990-91	1991-92
Total, all areas\1\.............	366.5	722.1	801.6	800.1	794.4	3.1	2.1	-0.2	-0.7	$592	$2,762	$3,578	$3,906	$4,194	8.2	5.3	9.2	7.4
United States\2\................	370.9	731.2	810.5	808.8	802,7	3.1	2.1	-0.2	-0.8	593	2,772	3,592	3,921	4,212	8.2	5.3	9.2	7.4
New England.....................	380.4	767.4	829.0	831.3	830.9	3.2	1.6	0.3	0.0	680	2,708	3,573	4,074	4,364	7.7	5.7	14.0	7.1
Maine.......................	330.1	756.1	868.8	871.3	872.8	4.0	2.8	0.5	0.2	586	2,369	2,744	3,068	3,292	7.1	3.0	11.8	7.3
New Hampshire...............	391.6	739.7	810.5	812.5	829.4	3.0	1.8	0.2	2.1	467	2,374	2,974	3,240	3,511	8.4	4.6	8.9	8.4
Vermont.....................	411.7	742.8	841.0	853.0	843.9	2.9	2.5	1.4	-1.1	515	1,990	2,569	3,017	3.154	7.6	6.0	13.5	4.5
Massachusetts...............	394.2	766.5	813.6	813.5	809.0	2.9	1.2	0.0	-0.6	708	2,971	4,029	4,541	4,896	8.1	6.3	12.7	7.8
Rhode Island................	375.4	829.6	853.6															

844.8 836.4 3.3 0.6 -1.0 -1.0
625 2,619 3,236 3,756 4,315 7.8 4.3
16.1 14.9
Connecticut..... 390.9 764.1 838.1
846.0 851.4 3.2 1.9 0.9 0.6
711 2,570 3,511 4,151 4,310 7.6 6.4
18.2 3.8
Middle Atlantic..... 388.1 768.2 834.7
831.7 830.0 3.1 1.7 -0.4 -0.2
578 2,771 3,933 4,249 4,581 8.7 7.3
8.0 7.8
New York..... 406.9 765.7 830.4
823.3 809.2 2.8 1.6 -0.9 -1.7
610 2,533 4,119 4,382 4,596 8.6 10.2
6.4 4.9
New Jersey..... 399.0 759.8 826.7
827.3 836.4 3.0 1.7 0.1 1.1
526 2,650 3,483 3,958 4,551 8.8 5.6
13.6 15.0
Pennsylvania..... 365.0 776.4 844.7
844.8 852.5 3.5 1.7 0.0 0.9
533 3,147 3,948 4,245 4,579 9.0 4.6
7.5 7.9
East North Central..... 350.2 725.9 834.4
837.0 833.8 3.5 2.8 0.3 -0.4
614 2,906 3,595 3,817 4.042 7.9 4.3
6.2 5.9
Ohio..... 353.6 718.4 846.3
846.3 846.7 3.6 3.3 0.0 0.0
585 2,792 3,824 3,977 4.053 8.3 6.5
4.0 1.9
Indiana..... 343.7 672.2 837.0
836.3 820.1 3.5 4.5 -0.1 -1.9
545 2,510 3,234 3,443 3,927 8.0 5.2
6.5 14.1
Illinois..... 339.2 693.4 788.1
792.9 792.1 3.5 2.6 0.6 -0.1
703 3,313 3,760 4,078 4,332 7.6 2.6
8.5 6.2
Michigan..... 379.5 804.3 871.4
872.9 881.3 3.4 1.6 0.2 1.0

532 2,991 3,749 3,973 4,117 8.7 4.6
6.0 3.6
Wisconsin..... 354.7 736.9 843.2
851.4 828.9 3.5 2.7 1.0 -2.6
639 2,527 2,877 3,066 3,404 6.8 2.6
6.6 11.0
West North Central..... 363.2 693.4 979.7
797.1 805.5 3.2 2.8 -0.1 1.1
558 2,627 3,108 3,620 3,494 7.6 3.4
4.9 7.2
Minnesota..... 389.0 624.8 682.5
694.9 711.3 2.4 1.8 1.8 2.4
601 2,447 3,101 3,235 3,308 7.3 4.9
4.3 2.3
Iowa..... 365.9 715.3 850.6
847.2 853.0 3.4 3.5 -0.4 0.7
505 2,282 2,753 2,914 3,161 7.6 3.8
5.8 8.5
Missouri..... 364.8 712.0 816.6
813.4 821.1 3.3 2.8 -0.4 0.9
544 3,118 3,514 3,624 3,986 8.2 2.4
3.1 10.0
North Dakota..... 441.2 730.7 853.4
839.1 850.3 2.7 3.2 -1.7 1.3
492 2,466 2,949 3,089 3,358 8.0 3.6
4.7 8.7
South Dakota..... 358.0 694.2 815.1
812.1 815.9 3.3 3.3 -0.4 0.5
514 2,281 2,714 2,894 3,037 7.5 3.5
6.6 4.9
Nebraska..... 352.5 634.2 808.8
799.4 810.2 3.4 5.0 -1.2 1.4
540 2,449 2,719 2,935 2,942 7.3 2.1
7.9 0.2
Kansas..... 365.3 765.4 850.0
848.0 848.3 3.4 2.1 -0.2 0.0
540 2,553 3,144 3,346 3,679 7.9 4.3
6.4 10.0
South Atlantic..... 350.5 740.4 827.7
825.0 825.8 3.5 2.3 -0.3 0.1
554 2,531 3,438 3,837 4,203 8.4 6.3

11.6 9.5
Delaware..... 368.2 770.9 843.6
840.3 870.7 3.5 1.8 -0.4 3.6
552 2,612 3,526 3,430 3,910 7.9 6.2
-2.7 14.0
Maryland..... 349.4 757.6 838.3
836.4 845.2 3.6 2.0 -0.2 1.1
564 2,975 4,190 4,563 5,113 9.1 7.1
8.9 12.1
District of Columbia..... 452.8 739.4 772.7
771.4 762.6 2.1 0.9 -0.2 1.1
570 3,774 5,019 5,476 6,035 9.9 5.9
9.1 10.2
Virginia..... 317.3 729.7 848.5
857.2 844.8 4.0 3.1 1.0 -1.4
516 1,976 3,127 3,438 3,590 8.2 9.6
9.9 4.4
West Virginia..... 342.2 692.0 828.6
834.7 844.4 3.7 3.7 0.7 1.2
489 2,575 3,197 3,601 3,907 8.7 4.4
12.6 8.5
North Carolina..... 324.0 727.9 852.3
862.8 858.9 4.0 3.2 1.2 -0.5
515 1,982 2,799 3,172 3,428 7.9 7.1
13.3 8.1
South Carolina..... 296.2 680.6 832.2
834.1 845.5 4.3 4.1 0.2 1.4
523 2,340 2,689 3,049 3,288 7.6 2.8
13.4 7.88
Georgia..... 320.2 743.5 843.8
840.6 849.8 4.0 2.6 -0.4 1.1
474 2,479 3,456 3,987 4,466 9.3 6.9
15.4 12.0
Florida..... 420.9 759.1 805.8
793.1 791.4 2.6 1.2 -1.6 -0.2
588 2,773 3,709 4,148 4,566 8.5 6.0
11.8 10.1
East South Central..... 332.1 698.1 846.9
853.8 843.2 3.8 3.9 0.8 -1.2
489 2,570 3,413 3,831 4,249 9.0 5.8
12.2 10.9

Kentucky..... 365.9 671.9 837.3
834.7 837.2 3.4 4.5 -0.3 0.3
458 2,395 3,424 3,657 3,923 9.0 7.4
6.8 7.3
Tennessee..... 354.8 678.7 853.4
859.9 836.6 3.5 4.7 0.8 -2.7
502 2,816 3,402 3,911 4,425 8.9 3.9
15.0 13.1
Alabama..... 322.7 743.8 848.9
854.6 858.6 4.0 2.7 0.7 0.5
490 2,502 3,596 3,958 4,420 9.1 7.5
10.1 11.7
Mississippi..... 283.2 699.9 845.1
868.6 840.0 4.4 3.8 2.8 -3.3
471 2,480 3,122 3,717 4,098 9.0 4.7
19.1 10.3
West South Central..... 374.8 687.4 825.0
829.6 817.6 3.2 3.7 0.6 -1.4
504 2,811 3,624 3,955 4,291 9.0 5.2
9.1 8.5
Arkansas..... 319.3 715.4 862.9
870.3 841.3 4.0 3.8 0.9 -3.3
466 2,550 3,155 3,640 3,821 8.9 4.3
15.4 5.0
Louisiana..... 343.4 653.5 821.1
832.4 828.0 3.6 4.7 1.4 -0.5
446 3,167 4,368 4,683 4,977 10.3 6.6
7.2 6.3
Oklahoma..... 416.1 677.8 878.3
887.6 828.0 2.8 5.3 1.1 -6.7
486 2,482 3,127 3,467 3,933 8.5 4.7
10.9 13.4
Texas..... 393.7 693.2 805.1
806.4 807.4 2.9 3.0 0.2 0.1
522 2,860 3,652 3,951 4,288 8.8 5.0
8.2 8.5
Mountain..... 417.1 716.6 772.7
770.5 740.3 2.3 1.5 -0.3 -3.9
560 2,637 3,992 3,471 3,720 7.9 4.5
5.4 7.2
Montana..... 416.5 679.7 823.5

842.8 805.8 2.7 3.9 2.3 -4.4
505 2,348 3,000 3,201 3,295 8.0 5.0
6.7 2.9
Idaho..... 408.8 714.5 862.5
875.9 830.4 2.9 3.8 1.6 -5.2
467 2,384 2,556 2,723 3,213 7.6 1.4
6.5 18.0
Wyoming..... 395.0 681.7 782.7
764.3 786.7 2.8 2.8 -2.4 2.9
432 2,804 3,182 2,999 3,267 8.4 2.6
-5.8 8.9
Colorado..... 475.4 704.0 740.8
753.3 723.9 1.7 1.0 1.7 -3.9
578 2,521 3,223 3,496 3,907 7.8 5.0
8.5 11.8
New Mexico..... 377.6 689.8 736.4
732.8 731.0 2.7 1.3 -0.5 -0.2
513 2,462 3,154 3,156 3,258 7.9 5.1
0.1 3.2
Arizona..... 431.7 758.1 774.3
760.2 704.3 2.0 0.4 -1.8 -7.4
612 2,896 3,692 3,876 4,008 8.0 5.0
5.0 3.4
Utah..... 346.0 713.1 808.2
799.5 799.4 3.4 2.5 -1.1 0.0
580 2,225 2,799 3,128 3,350 7.3 4.7
11.8 7.1
Nevada..... 414.9 688.9 721.2
711.2 703.7 2.1 0.9 -1.4 -1.1
532 3,243 3,903 4,006 4,376 8.8 3.8
2.6 9.2
Pacific..... 468.9 739.7 713.8
699.2 681.9 1.5 -0.7 -2.0 -2.5
630 6,153 3,853 4,305 4,467 8.3 -8.9
11.7 3.8
Washington..... 433.0 731.1 760.8
758.5 755.9 2.3 0.8 -0.3 -0.3
507 2,522 3,218 3,576 3,790 8.5 5.0
11.1 6.0
Oregon..... 392.6 716.2 707.8
694.6 680.0 2.2 -0.2 -1.9 -2.1

583 2,459 2,833 3,051 3,360 7.1 2.9
7.7 10.1
California..... 490.7 745.7 710.3
692.7 671.8 1.3 -1.0 -2.5 -3.0
653 3,379 4,138 4,661 4,794 8.5 4.1
12.6 2.9
Alaska..... 307.2 678.4 759.0
781.6 784.3 3.8 2.3 3.0 0.3
376 3,554 4,007 4,325 4,303 10.7 2.4
7.9 -0.5
Hawaii..... 407.4 709.3 589.9
583.9 574.9 1.4 -3.6 -1.0 -1.5
572 2,334 3,095 3,100 3,480 7.3 5.8
0.2 12.3

\1\Consists of United States, Puerto Rico, Virgin Islands, and other outlying areas.
\2\Consists of 50 States, District of Columbia, and residence unknown.
\3\Preliminary data.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, ``Annual Medicare Program Statistics,'' and unpublished data.

TABLE 5-38.--MEDICARE: SUMMARY OF RISK AND COST CONTRACTS BY
CATEGORY DATA AS OF JANUARY 1, 1994

Current contract summary	Number of contracts	Number of Percent	enrollees
TEFRA risk contracts:			

Model:					
IPA		74	69	916,482	
Group		20	19	339,631	
Staff		14	12	588,645	
Ownership:					
Profit		67	62	1,296,877	
Non-profit		41	38	547,881	
TEFRA cost contracts:\1\					
Model:					
IPA		16	62	123,332	
Group		3	12	12,073	
Staff		7	26	24,971	
Ownership:					
Profit		8	31	35,610	
Non-profit		18	69	124,766	
Percent of total medicare beneficiaries.		5.6			

\1\Does not include cost enrollees remaining in risk plans.

Note.--Data as of January 1994. IPA is the Individual Practice Association.

Source: Health Care Financing Administration.